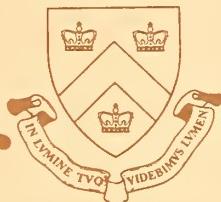


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PAYING THE HOSPITAL:  
FOREIGN LESSONS FOR THE UNITED STATES

By

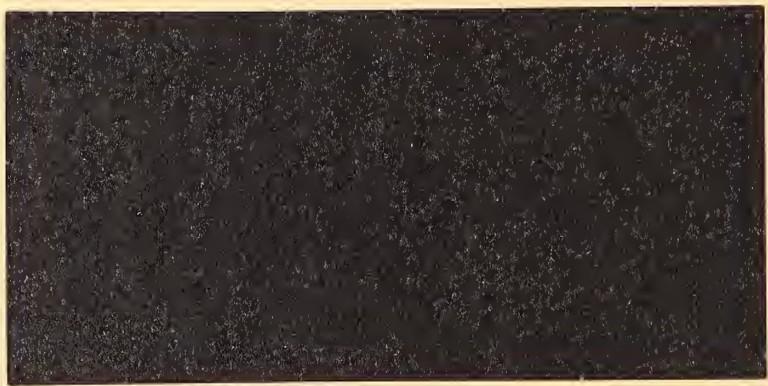
William A. Glaser

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## EXECUTIVE SUMMARY

Nonprofit and public hospitals originated in Europe as custodial and treatment establishments for the poor. For centuries, patients were not expected to pay cash, although many contributed their modest property and labor. Hospitals were not part of the cash economy: most owned rather than rented land and buildings; most produced their own fuel and food on their lands; labor was donated by religious as callings or by indigents in return for room and board. The owners of hospitals -- religious orders, lay associations, local governments -- had the task of finding needed resources in mind and in money. The middle classes usually did not go to hospitals, since they had homes and families; they were treated by doctors and midwives for fees at home.

During the nineteenth century, hospitals were transformed clinically and organizationally. New techniques in surgery and medicine reduced infectious diseases among patients and made cures possible. More persons were willing to enter nonprofit and public hospitals, including the middle classes. Hospitals entered the cash economy, since they had to modernize their buildings, buy equipment, hire employees, and buy supplies.

Physicians had been patronized long before the turning point for hospitals, and patients customarily had paid cash. Throughout Europe and (later) in North America, groups of self-employed craftsmen and employed workers formed mutual aid societies for several purposes, including the hire of doctors on retainers to treat members. During the nineteenth century, the sick funds for employees were expanded and stabilized, by means of financial and administrative help from many employers. When hospitalization became safer and more successful than home care, many sick funds agreed to pay their members' hospital bills.

As nonprofit and public hospitals became more complex and in need of cash, they raised funds from many sources. Patients in private rooms were charged by the day, and some ward patients were also charged. Sick funds agreed to indemnify their members. In some countries, the welfare offices of local governments and of private associations paid daily charges for their clients. In the absence of modern cost accounting, the charges were set to cover costs by intelligent guesswork, and they were collected unsystematically. Endowments yielded some income. Owners and managers constantly searched for money to pay the rest of annual operating costs, to buy new equipment, and to modernize the buildings.

For the last century in all countries, the costs of hospitals have steadily risen, usually faster than the consumer price index, absorbing a larger proportion of GNP. The trend has many causes. Once personnel were few, they worked long hours, and they received little pay. The wage bill steadily rose as hospital workers obtained normal

pay and shorter hours, as the higher quality care required more numerous and more credentialled staffs. Technology was introduced at an accelerating rate, and each new item was more expensive to purchase and operate. The new buildings to accommodate the complex care and middle class patients were steadily more expensive to build and operate.

In all countries, steadily higher proportions of the hospitals' total costs were met by charges to patients. To cover the charges, sick funds acquired more members and collected higher premiums. Laws mandated membership and benefits. When the unemployed and aged were added to membership by law, governments began to subsidize the sick funds from general revenue. When hospital costs outran the resources of the sick funds, several countries gave up trying to finance them through the channel of payroll taxes, and they switched to general revenue coverage of hospital operations and investment.

Proprietary hospitals evolved differently. When surgical and obstetrical innovations made institutional care superior to home care, middle class patients needed an alternative to the public and charitable hospitals. Their attending physicians set up small "private clinics" as extensions to their offices, where private patients could recuperate for several days. In all countries during the nineteenth century, the private clinics outnumbered the public and nonprofit hospitals and contained a large proportion of all beds. Patients personally paid their doctors in full for treatment and housing. During the twentieth century, the private clinics gradually diminished in number: the nonprofit hospitals installed private rooms for their medical staff's private patients; as medical care became more complex in technology and in staffing, the nonprofit and public hospitals got all the difficult cases and the private clinics could take profitably only the simple cases. Parallel to NHI, private health insurance spread to enable a few private hospitals to work on a larger scale, and proprietaries in some countries were admitted to national health insurance practice.

#### STANDARDIZATION

Once hospital economics everywhere was primitive. Each organization kept financial records in its own way. The hospitals' owners and managers raised money to pay their bills by whatever methods they could. Each organization charged and collected from some patients, experienced defaults from others, and decided not to bill others. Since managers did not use cost accounting, they fixed charges for procedures and individual patients by guesswork, merely to reduce the deficits that had to be covered by the normal fund-raising in the community. Hospitals differed in outside income, in reliance on all patient charges, and in the height of charges. Hospitals' reliance on charges steadily increased; the sick funds to cover bills spread in membership and grew in revenue.

Method and unit of payment. The rise of organized third parties to cover the hospitals' operating costs has brought about uniformity

within countries. Nations differ in their methods -- there are no standard international practices -- but all third parties and hospitals within a country converge on the same procedure, either by law or by custom. The United States is the last internally heterogeneous country, but the trend toward standardization is visible there too.

Countries with national health insurance and personal payments usually pay their nonprofit and public hospitals by all-inclusive daily rates. These became common during the nineteenth century in billing of private patients and in the billing of welfare offices for poor patients. Hospitals lacked the cost accounting to itemize services -- like the billing by doctors for their office care -- and gradually the sick funds and hospitals throughout each country became accustomed to the daily charge. If a government created a regulatory agency to arbitrate between hospitals and payers and to protect the interests of both, the regulators usually fixed on the daily charge because it was customary and easy to calculate. Some more itemized billing of private patients still persisted within nonprofit hospitals in a few countries, but it is unusual now. In contrast, the same American hospital bills payers by different principles, viz., comprehensive daily charges for some and itemized billing for others; posted charges for some and strictly cost-based figures for others.

An important reason for standardization of payment methods in Europe is recognition of common interests among the sick funds. They unite when negotiating with the hospitals, as in Germany. Or, they take for granted that all pay the identical rate set by regulators, as in France and Holland. In contrast, American third parties are rivals; each tries to minimize its costs and premiums by limiting the payment to the hospital, each tacitly invites the hospital to find its extra money from the other third parties, each hopes that the rival third parties will suffer high costs and competitively disadvantageous high premiums. If American payers united in negotiations, the hospitals would charge them with violating the antitrust laws, since the present disunity works to the advantage of the hospitals -- or, so they think.

In the long run, if they cannot have a completely free hand to charge everyone high rates, European and probably American hospital managers prefer to collect the same rates from everyone, at a level high enough to cover their costs. Low rates for some payers cause uncertainty, and the managers must struggle to make up the money from other payers or from donors. A sliding scale harms public relations: the hospital managers must conceal it, lest the overcharged patients and carriers complain.

Americans will be disappointed if they think that lower hospital charges for some patients lead to price-cutting competition among carriers, leading in turn to lower offers to the hospitals. In practice, the carriers that save money on the basic benefits use it to offer additional benefits. Competition in health insurance is in efficient servicing of claims and in the extent of benefits, not in lower prices.

Definition of allowable costs. The unit of payment is tied to the hospital's costs in some way. Because all payers within a country unite in paying the same charge to each hospital, they also unite in defining the costs that they will and will not cover. A regulatory agency performs the important function of expert analysis of the prospective budgets and end-of-the-year expenditure reports to make sure that all hospitals include the same types of costs when billing all payers.

In contrast, each American organized payer tries to minimize its liability by restricting the costs it will cover and by tacitly inviting the hospital to transfer the extra costs surreptitiously to the other payers. At times state regulatory agencies seem to move payers toward a consensus on the principles of reimbursement. But when government finances become tight, the national government's Medicare and the state governments' Medicaid revert back to much narrower definitions of what they will cover.

The attempts by each American carrier to attribute hospital costs to patients other than its own results from the unusual categorical evolution of American third party payment. Each carrier has a different type of patient, with different patterns of utilization and cost. European carriers were created by principles other than clinical need, they have always been partial cross-sections of the community, and they have become more inclusive and representative as they expanded.

Uniform reporting. Regardless of the method of payment, every developed country -- except the United States -- has uniform reporting of every nonprofit and public hospital's prospective budget and retrospective expenditures. I.e., just before the start of the fiscal year, every hospital fills out the same budget form according to the same principles, when it is seeking approval of a daily rate from regulators or negotiators, or when it is seeking installments on a global institutional sum from a government. At the end of the year, to account for its use of the money to the regulator or to the payers, all the country's hospitals fill out the same expenditure report. The report covers the entire finances of the hospital, not merely the subscribers of one third party.

Uniform reporting is expected by regulators (in countries with rate-setting, like France or Holland), by negotiating committees of third parties (in countries with negotiated rates), and in countries with full public financing. Only by uniform reporting can the regulators and payers understand the hospitals' submissions. Computerization of the reports is becoming common, and the regulators and payers detect the more wasteful hospitals by statistical comparison of peer groups.

Uniform reporting usually leads to uniform accounting. Since the regulators and payers expect all hospitals to fill out the budget and expenditure reports according to certain rules, hospitals tend to adopt the chart of accounts and costing practices that fit the reports. Uniform accounting may be mandated by the regulatory laws, so that -- if investigators or arbitrators are called in -- they can understand

the original records. A system can require uniform reporting without requiring that all nonprofit and public hospitals keep their original books in identical ways, as in Holland.

Hospital managers at first resist uniform reporting and uniform accounting, since their administrative work increases and the regulators and payers gain valuable information. The hospital association soon makes a virtue of necessity, using the reporting/accounting requirements to teach modern financial management to all the country's hospitals. Without legal or financial obligations, hospital managers drift along with simpler and diverse methods. Several hospital associations (such as Holland and Switzerland) call meetings of the managers in the same peer group to compare notes about methods.

In contrast, American hospitals resist nationwide uniform reporting and accounting. Only Medicare can require a common methodology. the American tradition of organizational autonomy and trade secrets -- practiced by hospitals as well as by business firms -- leads to resistance of SHUR and of other proposals for uniform reporting of hospitals' entire finances, even the nonprofit and public establishments. State regulatory agencies can compel or persuade some limited standardized reporting for their particular purposes, but only Medicare transcends state boundaries, some regulatory agencies have limited jurisdiction (perhaps only over the hospitals' Medicaid business), and most states have no regulatory requirements at all. Even when uniform reports are required by Medicare or by a state rate regulator, the hospital can keep its books by any conventional accounting methods, and an outside investigator cannot easily pry.

Proprietary hospitals. Hospital managers everywhere prefer a free hand, without giving away the information that strengthens the hands of regulators and payers. But nonprofit and public hospitals eventually concede, since the reporting obligation is a condition for the payment-in-full that relieves them of the constant struggle to balance their budgets.

The for-profit hospitals owned by doctors (and sometimes by others) share with private business in all countries the antipathy toward revealing too much to government and to sick funds. The doctors conceal their office accounts from sick funds under national health insurance and merely negotiate fee schedules that list estimated average charges for everyone. But since hospital charges are related to costs under all national health insurance programs, the sick funds insist that the private clinics submit the standard reports about prospective budgets and retrospective expenditures, if they want payment in full. Some proprietaries refuse the reporting requirements and try to survive with limited charges to patients and without investment grants from public funds. the larger proprietaries, however, cannot survive unless they become assimilated into the general hospital payment system, and most accept the reporting obligations along with the money.

## UNITS OF PAYMENT

Daily rates. Most countries use per diems because of custom and administrative ease. The goal is really to guarantee full costs of a hospital to perform its work without waste and without stinting. The daily charge is a simple way of delivering the money, and it is the result of elementary arithmetic rather than precise calculations about the components of care each day. The regulators or negotiators -- depending on the decision-making system in the country -- examine the totals and lines in the hospital's prospective budget, reduce some amounts that might be excessive, judge the reasonableness of the expected total patient-days, and calculate the average.

The daily charge has the advantage of administrative economy: a hospital can bill a sick fund for all its patients for a period by merely listing the number of patient-days for each patient, and multiplying the total by the hospital's particular daily charge. The many items appearing in bills in the United States are included in the European per diem. The simplicity is one reason why European hospitals have smaller administrative staffs than the American.

Usually the only separate billing is for the doctors. In countries where hospital doctors are paid by fee-for-service directly by the sick funds (e.g., Holland), the daily charge includes all other hospital costs. In countries where many senior doctors are full-time salaried, the daily charge includes their pay.

Global budgets. The intent of hospital reimbursement in other developed countries is to cover the hospital's operating costs. If the exactly predicted numbers of patient-days occur and if prices fulfil expectations, the budget is delivered. However, the total of per diems is rarely on precise target. Higher morbidity, a growing catchment area, or deliberate manipulation by the hospital staff might increase the hospital's work load and income. Patient-days might be fewer if the population is declining, if the hospital works more efficiently, or if unemployment causes a drop in the membership of sick funds.

Some critics of hospital finance have recommended paying the hospital their budgets directly, without the outcome depending on the fluctuating and perhaps manipulated number of patient-days. Usually global budgeting of a hospital is associated with a single payer, and usually with government. But several third parties can pool their funds and share in the hospital's budgets according to their percentage shares of the total work load, as in several Swiss cantons.

Usually global budgeting is adopted because of a breakdown in the capacity of private or national health insurance to deliver full reimbursement to hospitals. Hospitals may have too many patients who are covered by no insurance or by impecunious sick funds, they go bankrupt, and government rescues them with full Treasury payment of their annual budgets. Examples are Great Britain and Italy. Or, insurance may reach a ceiling in its voluntary membership, and the

hospitals themselves press for the full guarantee of costs that only complete Treasury financing can realize. An example is Canada. Under global budgeting, usually the prospective budget is examined and approved by a government agency, which then pays installments throughout the year. No item-of-service or per diems are used.

Global budgeting of hospitals always becomes involved in the total budgetary planning of the government. At first, as the hospital managers hoped, it is bottoms-up: the managers state what they need, argue with the government, and get most or all of it. But, particularly during periods of financial stringency, the system changes to top-down: the Treasury gives the spending Ministries their shares, the Ministry of Health allocates a total amount, and each hospital's share fits within the available total. The hospital must limit its services to the budget it is given by the government; it can no longer press government to supply the money it thinks it "needs." Global budgeting is ideal for the control of costs, but that was not what the hospital managers originally intended.

#### METHODS OF DECIDING PAY

Unilateral decisions. In a free market, each firm sets its own strategy and fixes its own prices. A hospital might charge what it can for basic care and specialized services, perhaps losing on some and profiting on others. It might develop a tacit sliding scale, diligently collecting from the rich and accepting bad debts from the poor. Certain comforts used by the rich -- such as private rooms -- may be over prices and profitable.

During the nineteenth and early twentieth centuries, all hospitals and private clinics in Europe and North America used such free and discretionary pricing. But unlike a business firm, no nonprofit or public hospital has ever met its entire budget by collecting such unilaterally set charges, much less earning a profit for reinvestment. The charges were designed to raise as much money as possible from patients and their sick funds, deficits remained, and the managers and governing boards devoted much effort to finding the rest of the money.

The sick funds had arisen before the nineteenth century to pay doctors in full for their members' office and home care. The sick funds fixed fee schedules according to what they could afford, and the doctors went along. During the nineteenth century, as hospital inpatient care became more tolerable to the workers and middle class, the sick funds offered to pay hospital charges in whole (by direct third-party payment to the hospital) or in part (by indemnifying the patient). The sick funds covered the new expenses by increasing their premiums and memberships. Statutory national health insurance greatly increased the coverage and extended the payroll tax collections to the employers, thereby raising much more money for the hospitals. By the late 1940's, European hospitals could cover their full budgets from third party payments.

Negotiations. Facing large third parties whose revenue was determined by laws, the hospitals could not behave like business firms, setting their own prices and maximizing their own revenue. The money was "public": the sick funds were nonprofit associations for social protection, their premiums were really taxes set by Parliaments and Ministries of Finance. The large majority of hospitals were nonprofit private and publicly owned establishments, and all bore a social responsibility to use public money efficiently and without waste. Laws about hospitals and about national health insurance guaranteed the hospitals full payment to perform their work efficiently, and they were expected to get no more money from this source.

Faced with large third parties administering public money and obligated to perform a public trust, hospital managers could no longer fix prices unilaterally and secretly. They had to discuss them with the sick funds, at first individually and soon in some collective form. Each hospital's budget and costs were and still are unique, and each hospital negotiates individually. In countries relying primarily on negotiated rates, such as Germany, the hospital managers face a committee of all sick funds, to agree on a daily charge binding all. The sick funds demand justification of the hospital's claims, and the hospital is expected to reveal its prospective budget. As in all collective bargaining, the hospital managers reveal as little as possible, overstating their costs and understating their outside revenue; and the sick funds try to pay as little as possible, on the grounds that the hospital's pleas of poverty are overwrought. In order to make the negotiation more factual, the national government of Germany has mandated full, uniform, and open reporting by the hospitals, backed up by uniform accounting in the books.

Every payment system has an appeals process. Its form is particularly influential on the outcome of payment negotiations. If the method of deciding deadlocks were weak, the sick funds could dictate the rates. Often government arbitrates deadlocks, and it is more generous to the hospitals, since government passed the laws guaranteeing full payment of the hospitals' legitimate operating costs.

Hospitals abroad are compelled to negotiate contracts with the sick funds. Without them, hospitals would collect nothing directly from the third parties, and the insured patients would be reimbursed little or nothing. American hospitals enjoy a much stronger bargaining position with Blue Cross Plans, since patients are reimbursed at very high rates if the hospital and Blue Cross cannot agree.

Hospitals can be paid generously or stingily, depending on the stance of the sick funds and the laxity of the appeals process. If the sick funds are independent of the hospital and must operate within a tight revenue ceiling from premiums, they are tough bargainers. American hospital costs rose rapidly in the past in large part because Blue Cross was allied with the hospitals as a collection agency from the public, because state insurance commissioners freely granted premium increases, and because hospitals and doctors could charge patients extra. But Blue Cross has become more independent, many state insurance commissioners

require it to bargain more strictly, and more of its policies provide payment in full. The American commercial insurers still have less leverage, because usually they only indemnify the patient. But the United States obviously is evolving toward the European pattern.

Rate regulation. The European regulator is not a representative of the public interest in restraining a venal private interest -- a common model for regulation in the United States. The European regulator is really a referee. He picks a rate that is fair to both the hospital and the sick fund. A reason for regulation rather than letting the two sides bargain is the complexity of hospital accounts. European sick funds do not employ large accounting staffs, and the hospitals are not completely candid. But a regulator has official power and the hospitals report more accurately; a regulatory agency that fixes the rates in health hires enough technical experts.

The regulators in France are the field staffs of the national Ministry of Health. They have the right to monitor all transactions of the hospitals owned by local governments, including price regulation to protect both the hospitals and their payers. The setting of the daily rate began when the officials needed to set reasonable transfers from one public account to another, viz., from the local social welfare office to the public hospital. But it has since been applied to all payments.

Holland's regulatory body is a joint committee representing both the hospitals and the sick funds, and receiving official status in law. Rather than leave the rate determination to power bargaining, the two sides hire expert investigators to analyze hospitals' budgets and recommend daily charges. The two sides on the committee could then bargain on the basis of the report, but in practice they accept the staff's recommendations.

Hospital rate regulation abroad bears many lessons for Americans. It cannot be effective if -- as often happens in the United States -- it lacks political support, and if it is based on a statute with unclear goals and with ambiguous grants of power. Rate regulation is not captured by providers if consumer interests (i.e., the sick funds) are vigilant and the civil servants' careers are secure. Constant alteration of the rules produces confusion; regulation becomes effective and generally accepted if everyone knows the rules. A regulatory agency that learns about hospital management can be a creative force in advising the directors and fostering a more efficient division of labor among organizations. If regulators can easily be over-ruled in the courts, they buy peace by generosity. Complicated rules, procedures, and payment units foster confusion and conflict.

Americans hope to find automatic regulation by formulae, lest a regulatory agency be captured by the providers or by corrupt politicians. But this is a mirage. The struggle among competing interests produces very complicated formulae, hard to understand and yielding unexpected results. Since no regulatory staff exists to defuse complaint and make exceptions, the system is clogged by lawsuits. Other countries have regulatory agencies that use judgment to apply the formulae.

American regulatory efforts -- in hospitals as in other fields -- are performed in policy vacuums: the statutory mandate is vague; often the regulators are independent both of line departments and of advisory commissions. But European experience shows how rate regulation -- and all other payment methods -- can be led by guidelines from national economic policy-makers. America's Voluntary Effort is a hesitant beginning.

Grants. Several countries scrapped hospital insurance because of its financial limits in economies with great inequalities or other barriers -- Great Britain, Italy, and Canada -- and government grants the hospitals their budgets in full. All countries with national health services -- Eastern Europe, most developing countries, and Britain -- employ this method. Sweden opted to pay all its hospitals in this way, since they were publicly owned, but government ownership can be reconciled with daily charges and rate regulation, as in France. Because of the limited resources of its sick funds, Switzerland has a mixture of per diem payments by the sick funds and cantonal grants for the rest of each hospital's budget.

If the hospitals are owned and managed by private persons or by levels of government other than the payer, several of the steps in negotiation and regulation are followed. The hospital submits a detailed prospective budget to the payer, and the latter's analysts examine and often cut it. If the payer is given less money from its public Treasury than the total of all hospital budgets, it asks all or most of the hospitals to revise their submissions. Because of the fiscal restraints since the late 1970's, the trend is to reduce the haggling between hospital managers and the payer's financial analysts by simply telling each hospital the amount it will get. Deficiency appropriations have become rare: the hospital is warned that it must look elsewhere to cover any deficits.

Global budgeting and public grants can be administered strictly, so that hospital spending rises only slightly faster than the general inflation rate and occasionally even lower. Most countries with national health services, such as Britain and the Soviet Union, devote a lower proportion of GNP to health and hospitals than countries with national health insurance do. But this depends on conscious public priorities. It is possible to spend a great deal on health and hospitals under public budgeting, as in Sweden. NHI spending and utilization is determined more by patients' demand and the judgments of doctors. An NHS can limit spending and facilities, forcing patients to queue for the limited services. Policy-makers under NHS as well as in all other countries are thereby presented with a central problem that they invariably evade, viz., the criteria for prioritizing patients and limiting care.

Some American reformers think global budgeting and grants generate incentives to efficiency: the hospital is given a lump sum, the managers have full discretion, and the hospital keeps its savings. However, all incentive reimbursement schemes -- like this one -- fail to work out, either abroad or in the United States. Third parties want

a full accounting of how their money is used for their members, and they never give the hospital managers complete discretion. All insurance money and public grants are considered "public" rather than "private" in all countries, hospital managers are not supposed to use them at their discretion, and the third parties always expect that savings will go back to their true owners. Third parties are suspicious that savings are due to underservicing. If the savings are due to declining utilization or greater efficiency, the payers try to give less money next year, and hospital managers fight budget reductions more than anything else. Cutting spending pits the hospital manager against the doctors, and his life is happier if he leaves them alone.

#### COVERING THE HOSPITAL'S COSTS

Reimbursing costs v. paying charges. Much American rhetoric assumes that cost reimbursement of hospitals invites inflation and sloppy management, while charge-based payment instills discipline and efficiency. The dichotomy is false. No organized payment system automatically gives hospitals whatever the managers claim as their costs. No hospital system on a large scale can survive simply on arbitrary charges, since usually they cannot cover all actual or intended costs. Third parties never accept the hospitals' posted charges and hospitals never accept the carriers' own schedule of indemnities. Every cost reimbursement system begins the year with interim rates and in practice, therefore, is no different from a system of negotiated charges.

Nonprofit and public hospitals everywhere are supposed to break even and use public money prudently; sick funds and government payers are supposed to use public money efficiently. The regulators and payers do not agree to pay whatever hospitals want but insist that the hospital document its needs, in prospective budgets and in end-of-the-year expenditure reports. The only basis on which payers and hospitals can agree is reimbursement of the costs of efficient operations. The regulation and bargaining therefore is devoted not to fixing a "fair price" but to the necessity of certain claims by the hospital for specific items of cost.

Once American hospitals -- like foreign ones in the past -- fixed charges bringing in a substantial part of the budget, while the rest was covered by donors. Cross-subsidization has been common in the United States, with the labs, x-ray, pharmacy, and the OPD bringing in extra money. Cross-subsidization has been less common in European nonprofits and publics, because of the all-inclusive rate. The calculating conventions resulting from Medicare have brought charges in the United States close to costs in all departments, making itemized charges somewhat obsolete. Where Blue Cross Plans pay charges rather than costs, the limited negotiations result in bringing them close to costs, although the absence of detailed reporting and scrutiny makes it an approximation.

Cost-based reimbursement is common throughout health. In theory medical associations and sick funds abroad negotiate a charge schedule for doctors' pay, and the outcome could result entirely from power bargaining. In practice, they converge on the practice costs for each act plus an honorarium. In the absence of the detailed cost reports in hospital finance, the medical associations and sick funds guess at the profession's average costs.

Prospective v. retrospective reimbursement. The political power of the medical profession in the United States has blocked the method of determining pay that is normal in every other country, viz., annual negotiation of a fee schedule or salary scale between the medical association and sick funds or between the medical association and doctors' employers. However, something as complicated and expensive as hospital payment cannot avoid advance agreement. All cost-based payers agree on interim rates with hospitals, in the United States as well as abroad.

The true distinction is not prospective v. retrospective but whether the hospital can run a deficit with confidence of getting a supplement, either extra money this year or an addition to the cost-based rate in next year's negotiations. Some American state regulatory programs and some state Blue Cross Plans have been strict, particularly as payers are constrained in their own revenue. One reason why several European countries have had surprisingly great increases in hospital costs -- in particular, France and Holland -- has been the generosity of their end-of-the-year settlements. Hospitals could overspend with impunity. German costs rose more slowly in large part because the sick funds would add nothing to the initial rate.

Charity and bad debts. Once all public and nonprofit hospitals everywhere were charities for the unfortunate. Managers once tried to overcharge their private patients to defray the costs of the many who paid little or nothing. Prepayment has spread in every country, to relieve the financial problems of the hospitals, enable them to give the more expensive modern forms of care, enable the managers to concentrate on internal management rather than constant public fund-raising.

National health insurance has been based on employment, leaving the poor and the retired uncovered. Social welfare offices of local governments and of private organizations paid for the unemployed and the retired persons without pensions. Recently they have been folded into the sick funds, thereby giving them full benefits and giving the hospitals normal paid-in-full rates. Since the unemployed and retired pay no premiums, the government subsidizes the sick funds. In countries where too many persons were not covered by NHI and the hospitals were going bankrupt from their non-paying load, such as Britain and Italy, the system was changed to a national health service, to full coverage of the population, and to full Treasury financing. A country with a hospital system and private insurance much like the United States -- viz., Canada -- switched to full government financing and universal coverage, because of the many non-payers.

The United States is the last developed country with a large number of bad debts and charity cases. The Hill-Burton Act even requires the managers to find non-payers, an inconceivable idea elsewhere. As a result, American hospital managers juggle their accounts and shift costs among payers in ways that all other developed countries have eliminated. America's urban public hospitals experience a financial crisis reminiscent of the nineteenth century.

#### PAYMENTS BY PATIENTS

Cost-sharing for the basic benefits varies, by purpose. Nearly every country's NHI or NHS requires copayments for drugs to deter waste. A few -- not all countries -- require small coinsurance in fees under NHI for physicians' services, sometimes to deter unnecessary visits and in other countries to relieve financial pressure on the sick funds.

The least cost-sharing occurs for the most expensive care, viz., hospitalization. If the purpose of NHI and NHS is to make services available to those who need it at difficult times, policy-makers think that the patient's finances should not be a barrier, that provision should be decided on clinical grounds. In the few countries where cost-sharing is required for inpatient hospitalization, the patients who are most likely to be deterred are exempt, i.e., the poor, the elderly, the severely ill, and those with catastrophic bills.

Cost-sharing rules in every other country are simple and known to the patient in advance. Except in the United States, patients do not discover long afterward that they must pay substantial parts of their bills. Unlike American Medicare, where the cost-sharing rates change every year, the foreign rates remain the same. Few countries rely on copayments as much as the United States, few have deductibles; copayments require frequent changes, and deductibles in health insurance are difficult to understand.

Insurance. The populations of all countries -- including the United States -- prefer more complete coverage, even if premiums and taxes are higher. Health insurance premiums are lower in the United States than in any other developed country because its insurance coverage is less complete: only for limited inpatient stays, low indemnities for physicians' fees.

Besides the basic NHI coverage, many citizens abroad buy private insurance for any cost-sharing or for benefits omitted from the basic package.

The share in the payroll taxes by employers and employees is part of the full package of social security programs and payroll taxes. The shares abroad are decided by law, not by labor-management bargaining and no longer by the employer unilaterally. If anyone wanted the worker to pay more of his basic health insurance premium, the entire

package of social security taxes would have to be redesigned, and the total shares would remain the same. All premiums are counted by employers as tax-exempt business expenses, like the wages.

The American system of leaving the employers' share to labor-management negotiation gives the employer an incentive to spend as little as possible. Compared to the higher payroll taxes and generous benefits abroad, the result in the United States is really "underinsurance" rather than "overinsurance."

Private practice. Once every country had a double system: charitable hospitals with few or no point-of-service charges for the poor and workers, private clinics for those with cash; third party payment for the workers, personal payments (perhaps with insurance reimbursement) for the middle and upper classes; general practice for the poor and specialty practice for the rich.

Official NHI and NHS practice has steadily grown within each country and private practice has diminished. Third party coverage has become universal nearly everywhere for a basic package of benefits; the middle and upper classes are members either compulsorily or (because it is a good buy) voluntarily. Hospitals and doctors' offices have become more attractive in all developed countries. Therefore the middle and upper classes usually rely on the benefits under NHI and NHS, because they have already paid for them. If the richer person wants a special extra benefit, such as a private room in the hospital, he pays out-of-pocket or with the help of a supplementary insurance policy sold by the official sick funds or sold by private companies. The senior physicians in nonprofit and public hospitals now spend all their time on the premises, instead of going off to private clinics for most of the day; they earn high salaries or fees for treating NHI and NHS patients; and they have fewer private patients.

Some private hospital care remains. By paying the senior hospital doctor a private fee, the patient gets more personal attention. If the local hospital is crowded, the patient may be admitted to a private clinic for simple elective care. The patient may not personally pay the physician or private insurance company, but the private care is a fringe benefit of his job in business management (in Britain and Germany) or in the civil service (in Germany).

Because any citizen can join NHI or use the services of an NHS, private practice keeps its fees low. Private for-profit hospitals are very cautious, lest they quickly price themselves out of the market. They take the less expensive short stays rather than provide a complete alternative to the nonprofit and public hospitals. They usually charge lower rates than the nonprofit and public hospitals, since they must leave the patient enough cash to pay the doctors. The for-profit hospitals rarely earn net profits, because their rates are low and because the sick funds (if they have agreements) do not recognize profits as allowable costs. The for-profit hospitals survive by sharing in their doctors' private fees.

## INVESTMENT

Once in every country, buildings and heavy equipment were donated by owners, benefactors, and governments. That remains the pattern in most countries. Public investment funds are common. Plans can be drawn and implemented ensuring that expensive installations and expensive programs do not proliferate excessively.

American construction and equipment were constrained by reliance on donations and public grants until a sudden and unexpected change during the 1960's. Medicare, Medicaid, Blue Cross, and private reimbursement recognized the repayment of debt as an allowable cost in calculating rates. Because rates were generous, lenders considered hospitals a good risk. Managers were confident they could bring in the revenue to amortize large debts through the case-finding and energetic treatments by their doctors. New buildings and new equipment spread with little restraint. Borrowing and repaying in this fashion gave hospital managers and medical staffs great independence, an incentive to compete with other "nonprofit" hospitals for market share, and an incentive to increase work and costs.

Only one other country -- the Netherlands -- has relied so extensively on borrowing in the private capital market. Its hospitals too have undergone spectacular increases in modernization and in costs. Its hospitals too have evaded strict planning controls.

Mere CON's are no substitute for public grants as a force to restrain the proliferation of underutilized services and to induce a cooperative division of labor among hospitals. Disallowing the costs of disapproved services from the rates can discourage their installation only if the disallowance is complete -- i.e., capital costs and all operating costs are excluded from the charges for all patients. Like so many constraints, the American limitations are weak (e.g., excluding only capital costs and only from Medicare reimbursement), they are not enforced in actual practice, and they invite contempt.

It is very difficult to use planning agencies and rate regulation to force the closing of privately owned hospital beds. Even publicly owned beds can be closed only with difficulty, because of community protest. Usually a deal converts the acute beds to something else, such as chronic care.

## WORKERS

Once hospital workers in all countries were paid little, worked long hours, and received much of their income in room and board. The situation changed rapidly in Europe after World War II, thereby causing great increases in hospital operating costs. Nearly all countries now recognize the hospital workers' unions and grant them the same wages as comparable occupations. Often the wages are indexed to inflation

or linked to the rest of the society's. Labor relations therefore are taken out of contention.

The Anglo-Saxon countries still rely on plant-level bargaining; American hospitals try to avoid all bargaining by fighting the mere recognition of unions. Britain and the United States pay lower wages than Europe but pay a heavy price in conflict. America's low wages enable it to staff its hospitals more lavishly than do other countries.

The United States has achieved the world's highest levels of hospital spending without the single largest force for high costs, viz., high wages. America's biggest cost explosion is yet to come.

#### DOCTORS

The training, clinical habits, and financial incentives of hospital doctors conduce to more work and higher costs, not to fiscal restraint. Appealing to managers alone to make hospitals more efficient and more economical is futile, since a key to hospital finance is the organization and motives of the doctors.

Europe's hospitals have structures that make feasible the participation of the doctors in the financial management of the organization. The smaller and more select number of doctors in a closed European staff is easier to lead -- in both quality and cost -- than the large number of detached members of an open American staff. If the hospital must submit applications for limited investment money by priority, the medical staff becomes very active discussing the merits of all schemes, framing the serious proposals, and ranking them. After these experiences, the doctors become more conscious of needs and costs than they can from exhortations.

#### MANAGEMENT

A hospital cannot be run like a commercial and industrial firm manufacturing "capital goods" or "consumer goods." It is one of society's institutions to handle misfortune. It has a different mission from maximizing its cash return: it is supposed to make health and give comfort, not make money. If someone cannot pay, the nonprofit and public hospital admits him anyway and finds the money elsewhere, as it always has done.

European hospital managers are often aware of larger obligations. Many hospitals are part of religious groupings. French public hospital managers belong to an elite national corps; their careers depend on fulfilling national policies (such as restraining costs) as well as pleasing their employers in the commune. The hospital associations in many countries bring managers together regularly to share experiences. In contrast, the orientation of the American hospital

manager is toward his own organization, and he is motivated to grow at the expense of others.

As in many other economic sectors, competition among hospitals increases costs of the system rather than reduces them. (Cutting prices to gain sales is not the same thing as cutting costs.) Competition among hospitals leads to adding new equipment and new services, in order to attract new patients. Rather than struggling over a finite market, doctors are encouraged to expand it. Competition leads to bankruptcies in areas with few payers, but government and charitable organizations would not tolerate this sort of "rationalization of production." They would have to step in to preserve hospital services there.

#### DETERMINANTS OF COSTS

The motive for most American research about hospital finance during the last decade has been restraint on rising costs. Experiences abroad show certain administrative arrangements that restrain costs, others that allow spending to increase. In the real world, of course, each administrative device is combined with many others in a system; some other characteristics have the same effect, others work in opposite directions. The following are principal influences on levels of costs, as they usually operate in practice abroad. These are organizational influences, which could be emulated in the United States -- if reduction of spending is a policy goal.

| <u>Determinant</u>                       | <u>Higher Costs</u>                     | <u>Lower Costs</u>                                   |
|--|---|--|
| Method of Payment                        | Rates related to services rendered      | Global budget  |
| Pricing and billing                      | Itemized                                | Bundled  |
| If global budgeting and public grants    | Bottoms-up                              | Top-down   |
| Source of money                          | Insurance, especially private           | Government Treasury                                  |
| Characteristics of payers:               |   |  |
| (a) Number                               | Many                                    | One or few   |
| (b) Relations among payers               | Rivals                                  | United   |
| If rate regulation, nature of the agency | Commission dominated by interest groups | Line agency of government, staffed by civil servants |

| <u>Determinant</u>   | <u>Higher Costs</u>                                   | <u>Lower Costs</u>                     |
|--|---|--|
| Procedure of the regulator or grantor:   |   |  |
| (a) Parent bodies issue guidelines about allowable increases                                   | None. Or, few and vague.                              | Yes                                    |
| (b) Can prescribe allowable increases in utilization, not merely rates                         | No  | Yes                                    |
| (c) Can authorize any new jobs in hospital   | No  | Yes                                    |
| (d) Have voice in planning of building and programs  | No  | Yes                                    |
| Uniform reporting by hospitals to regulators and payers  | No  | Yes                                    |
| Interim monitoring during the year by the regulator or grantor                                 | No  | Yes                                    |
| (a) Expenditure reports  | No  | Yes                                    |
| (b) Liaison officers   | No  | Yes                                    |
| Possible increases in budget or rates during year  | Yes   | No                                     |
| Carryover of deficit into next year  | Yes   | No                                     |
| Relations between reviews of last year's expenditure report and next year's prospective budget | Combined  | Separate                               |
| Regulator or payer can examine the hospital's books  | No  | Yes                                    |
| Scope of hospital budget review by regulator or grantor  | Inpatient only  | Inpatient and outpatient               |
| Subsidies by government, if any  | To sick funds   | To hospitals directly                  |
| Planning of hospital services:   |   |  |
| (a) Does it exist  | No. Or, indicative planning with voluntary compliance | Yes, with sanctions for non-compliance |

| <u>Determinant</u>  | <u>Higher Costs</u>                   | <u>Lower Costs</u>                            |
|---|---------------------------------------|---|
| (b) Coordination between planning and reimbursement.<br>If hospital refuses to cooperate: | Payer reimburses patient at high rate | Payer reimburses patient little or nothing    |
| (c) Source of money for new building and major equipment                                  | Borrowed, with amortization in rates  | Granted, with no amortization                 |
| <b>Organization of hospital:</b>  |                                       |   |
| (a) Position of individual establishment  | Autonomous                            | Part of regional or larger system             |
| (b) Orientation of the manager  | His single unit                       | Larger collectivity                           |
| (c) Function  | Teaching                              | Non-teaching                                  |
| <b>Physicians:</b>  |                                       |   |
| (a) Medical staff structure   | Open                                  | Closed  |
| (b) Relations to hospital   | Hospitals compete for doctors         | Doctors compete for hospital posts            |
| (c) Authority of regulators or grantors over pay of senior hospital doctors               | No                                    | Yes   |
| (d) Payment of senior doctors   | Fees                                  | Salaries                                      |
| <b>Wage determination:</b>  |                                       |   |
| (a) Scope of decisions  | National or regional                  | Each unit                                     |
| (b) Number covered by agreement   | Entire hospital work force together   | Separate contracts, each for different period |
| (c) Connection with rest of labor force   | Linked                                | Not linked                                    |
| <b>Standards by law:</b>  |                                       |   |
| (a) Quality of personnel  | Strong                                | Weak  |
| (b) Safety  | Strong                                | Weak  |

A system can be expensive not only in money but in contention. Americans are concerned about cutting health care costs but take for granted a level of bickering that is inconceivable in nearly every other developed country. Weary officials in American governments are belatedly realizing this is a problem, at least as important as the loss of money. The following are some system attributes that result in high and low conflict in hospital regulation:

| <u>Determinant</u>                                      | <u>Higher Conflict</u>                                  | <u>Lower Conflict</u>                   |
|---|---|---|
| Life of the statute                                     | (a) Must be renewed frequently<br><br>(b) Amended often | (a) Permanent<br><br>(b) Amended rarely |
| Power of legislature                                    | High  | Low                                     |
| Role of courts  | Active, overrules regulators and legislators            | Passive, accepts executive discretion   |
| Security of the civil service                           | Low   | High                                    |
| Method of regulation                                    | Automatic formulae                                      | Personal administration                 |
| Complexity of the system in rules and in administration | High  | Low                                     |
| Stability in the rules                                  | Changes are frequent and numerous                       | Changes are rare and few                |
| Coverage of litigation costs                            | Included in budget for care of patients                 | Cannot be passed on to third parties    |

Whether a system is "generous" or "stingy" has no effect on contention. The biggest spenders include a country that placidly accepts government decisions (Sweden) and one that constantly fights and evades them (the United States).

## CHAPTER I

### INTRODUCTION

Health expenditures have steadily mounted in every country, exceeding 10 per cent of GNP in several at the time of writing. In its share of total health expenditure and of GNP, hospitals too have steadily risen. By now, hospitals account for about half of all health spending -- more in some countries, less in others -- and absorb between 3.5 and 6 per cent of GNP.<sup>1</sup>

Once the public policy issue was how to improve the buildings, equipment, and staffs of hospitals, i.e., how to spend more money on the capital and operations of hospitals, and how to find it. By the 1970's, the problem was limits and balance. Finance officers of governments were the principal constituency for cost containment. In countries where expenditures for patient care was run through the general Treasury (such as Canada, Britain, and American Medicaid), health and hospitals for a while replaced military defense as the principal issue in setting budget shares -- i.e., whether health was absorbing "too much" of the country's GNP and of the country's government resources, where the constantly increasing share would stabilize, whether the increasing expenditure was yielding benefits. In countries where expenditures were run through special governmental health insurance carriers (such as France, Sweden, and American Medicare) government finance officers worried about the future bankruptcy of the accounts, the need to rescue them by Treasury subsidies, whether stopgaps like higher patient cost-sharing were really cost-reducing and were politically feasible. In countries where health and hospitals were paid by private carriers (such as Germany, Holland, and American Blue Cross and commercial insurance), government officials were responsible for setting or approving the premiums and payroll taxes, and they worried that too much of the national income was being redirected through this channel, that health providers were profiting without giving an adequate return, that health services were too inefficient and wasteful, that the premiums and payroll taxes would destroy incentives to work

and invest, that the premiums and payroll taxes would become politically unacceptable. The executives of the carriers themselves worried that premiums and payroll taxes might soon be limited, causing them to go bankrupt; that the steady rise of hospital costs was taking money better spent on other forms of care.\*

The rise in all clinical care expenditure and the greater share for inpatient hospital work by the 1970's led to widespread misgivings by policy-makers in clinical affairs and in public health. Technologically advanced hospitals might be overtreating patients, who might be better off with primary care. Many basic treatments and tests were being done unnecessarily in the more expensive hospital instead of in ambulatory facilities. Too much effort and money went into treatment, not enough into prevention, many said.

Because of its diffusely arranged payment system -- direct government spending under Medicaid, a public social security account under Medicare, state insurance rate regulation of Blue Cross, Blue Shield, and commercial premiums -- the United States became aware of the hospital cost explosion early. It had adopted all these programs with the euphoria typical of American culture, in a competitive urge to offer beneficiaries more. Use of the hospital and reimbursement of its costs were generous entitlements, with few restraints on payments. Europe had adopted hospital prepayment and hospital insurance earlier, but usually with some methods of limiting prices. Isolated from other developed countries geographically and mentally, the Americans during the 1970's searched frantically for methods of their own to contain health and hospital costs. An enormous volume of discussion papers and research reports accumulated, confined to the Americans' own experience. Many new methods were proposed; some were adopted, usually on a very limited scale, and often they were revised or dropped.\*\*

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\*While health spending rises in all countries faster than consumer prices and GNP, hospital spending usually rises faster than other health spending. In other words, hospitals absorb a larger proportion of all money devoted to health.

\*\*An unstructured society with unstable policies cannot accomplish anything for very long. A particularly frustrating experience in hospital finance has been the much-hailed reduction of hospital

Meanwhile, European governments, carriers, and health administrators were more aware of each others' problems and methods; they developed a partial consensus in definition of the health cost problems and in methods of containment.

Another problem facing the Americans has been the extraordinary complexity of their method of paying hospitals.<sup>4</sup> It is not only more complicated than any other country's payment system, but probably unique among sectors within the American economy. The methods vary across the United States.

#### PURPOSES OF THIS RESEARCH

This project examines how hospitals are financed in the other principal developed countries, both for capital investment and for the costs of caring for patients. It examines also how the other countries have tried to contain the rise in costs, within the requirements of optimum care.

One general objective of the research is to explain why the United States developed its current practices. This can be understood only by comparative history. A century ago, the hospitals of Europe and North America were remarkably alike in organization and in financing. However, certain crucial turning points occurred: around the turn of the century, Continental Europe and the three Anglo-Saxon countries (Britain, Canada, and the United States) moved in different directions in financing methods; just after World War II, Great Britain

spending during the first year of the providers' own Voluntary Effort to Control Health Care Costs (1978 and 1979), with the resumption of increases thereafter.

| <u>Year</u>              | <u>Increase in hospital expenditures in %</u> | <u>Increase relative to CPI</u> |
|--------------------------|---|---------------------------------|
| 1977                     | 15.6  | 2.4                             |
| 1978                     | 12.8  | 1.7                             |
| 1979                     | 13.4  | 1.2                             |
| 1980                     | 17.0  | 1.2                             |
| 1981, First eight months | 18.3 (annual rate)                            | 1.7                             |

and Canada changed fundamentally; the United States at present practices the modern descendent of the classical "liberal" approach to hospital finance, while Britain/Canada and Continental Europe (with a few exceptions) have two other styles. Therefore, one purpose of comparative research is to enable the United States to understand itself better, its unique features, its scope for exceptional attainment beyond that of other countries, but also the eccentricities that result merely from historical events and lack functional advantages. The present discussions about America's troubled hospital sector today seem to realize that America is somewhat unique but fail to say why.

The other general objective of this project is to identify specific methods used abroad in the payment of the hospital and in the control of its costs. The present manuscript cites the principal difficulties in the financing of hospitals in the United States and describes methods of handling them in the countries most similar to the United States. Suitably adopted, these methods might be used here.<sup>5</sup> Many other American institutions -- including the hospital itself -- have been copied from foreign precedents.

The research has had four specific goals:

1. Systematic descriptions of the methods by which each of the other developed countries finances hospitals and controls their costs. Six others were selected: France, West Germany, The Netherlands, Switzerland, Great Britain, and Canada. This part of the work has been the foreign analogue of the first stage of Abt Associates'<sup>6</sup> National Hospital Rate Setting Study.
2. Lessons from abroad that can yield better understanding of the United States and specific methods that might be emulated here. This work is summarized in the present manuscript.
3. Identification of data sets in each foreign country that might be used in a statistical analysis of the effects of different methods of paying hospitals and controlling costs.
4. Codification of information obtained from other developed countries and from the United States, to produce a summary of how hospitals are financed and regulated. This analysis and writing will be done in the future.<sup>7</sup>

## RESEARCH METHODS

From 1979 through 1981, working alone, I collected information about the methods of paying hospitals in Switzerland, The Netherlands, France, Canada, England, and West Germany. (I list them in the sequence followed.) I spent two or three months in each country, learning the following information, where applicable to the financial system there:

1. Overview
  - (a) The general pattern of health and hospital services in the country.
  - (b) The general pattern of health insurance in the country.
2. Accounting methods by hospitals. How they keep their books.
3. Reporting by hospitals
  - (a) Financial reporting to the agency that decides the rates or that grants money to the hospital.
  - (b) Financial, administrative, and clinical reports to the Ministry of Health or to the Census Bureau.
4. How the hospital develops its claim for higher rates or higher grants next year.
5. How the paying agencies (such as the sick funds or government Ministry) evaluate the hospital's claim and develop their own offer. How regulators and investigators work.
6. Development of guidelines for use by the hospital, the regulator, or the grantor.
  - (a) How guidelines (e.g., FTE-bed ratios for personnel) are developed by parent organizations, such as Ministries of government, national associations of hospitals, and national associations of sick funds.
  - (b) Data systems that yield information used by hospitals and sick funds in making their decisions. Principles of designing classes and peer group comparisons.
7. How the components of the hospital's total costs are decided. Whether any of the following decisions are coordinated with the decision to set rates or grant budgets:

- (a) Wage rates and conditions of services of hospital workers.  
Labor negotiations. Any guidelines and restraints by higher authorities, such as wage policy by government.
  - (b) Wage rates and conditions of service of hospital doctors.  
How their salaries are negotiated. How fee schedules are negotiated. The mix of salaries and fees in determining their work schedules and incomes.
  - (c) Buildings and equipment
    - (1) Sources of investment money. Government funds, special public funds, private capital market.
    - (2) How hospital develops its request.
    - (3) Negotiations between the grantor or lender and the hospital. Whether future operating costs are considered.
    - (4) Role of sick funds in investment grants.
8. Events in the meetings between hospitals on the one hand and, on the other hand, depending on the country's system, the rate regulators, negotiators from the sick funds, or grantors of government money.
  9. Appeals procedure.
  10. Billing and cash flow.
    - (a) Collections from sick funds.
    - (b) Collections from patients if
      - (1) Patient is not covered by any health insurance.
      - (2) Patient is private.
  11. Variations in the payment system.
    - (a) For-profit private hospitals compared with the nonprofits.
    - (b) Teaching hospitals compared with the nonteaching.
    - (c) Special payment rates different from the main ones.
    - (d) Different administrative and decision-making arrangements in different parts of the country. For example, variations among provinces in federal systems.
  12. Statistics about the use and financing of hospitals.
  13. Perceptions of strong and weak points among persons in the country. Trouble spots in the politics, administration, and finance of hospital affairs.

In each country, my field research has relied primarily on interviews with persons involved in hospital finance. The interviews have been qualitative, in their flexible style of posing and answering questions; but a definite set of topics is covered for each respondent, viz., a systematic description of his work. Interviews lasted from one to three hours apiece.<sup>8</sup>

In each country, I interviewed the following persons about their work in the following topics:

1. Ministry officials in national government.
  - (a) Finance and Budget.
    - (1) If the country uses them, social security taxes, subsidies to sick funds, subsidies to hospitals.
    - (2) If the country uses them, appropriations for the hospitals' operating costs.
  - (b) Ministry that oversees the health insurance system.
  - (c) Ministry that oversees the hospitals.
    - (1) If the country uses them, guidelines for rate regulators.
    - (2) If the country uses them, the distribution of grants to hospitals for operating costs and investments.
    - (3) Drafters of new laws and regulations about hospital finance.
  - (d) Statisticians who gather and report data about hospitals.
2. Headquarters of national and regional hospital associations.
  - (a) Participants in any negotiations about new laws and regulations.
  - (b) Participants in any negotiations about contracts and principles of payment.
  - (c) Experts in giving advice about finance to member hospitals.
3. Headquarters of national and regional health insurance associations, if they exist in the country.
  - (a) Participants in any negotiations about new laws and regulations.
  - (b) Participants in any negotiations about contracts and principles of payment.

- (c) Experts in giving advice about hospital finance to member sick funds.
- 4. Directors and finance officers of several individual hospitals. Occasionally, a chief of service.
- 5. Officials of some local sick funds (if they exist in the country) who:
  - (a) Negotiate with hospitals over rates.
  - (b) Or, testify before rate regulators.
  - (c) Review the hospitals' bills and order payment.
- 6. Officials of the rate regulation office, if they exist in the country.
- 7. Local officials of the national or provincial government who distribute money to the hospital, if that method is used in the country.
- 8. Officials of the medical association who specialize in negotiating the pay rates for specialists.
- 9. Officials of the trade unions who negotiate pay and working conditions of hospital workers.
- 10. Scholars who have done research about hospital finance.

Besides field notes from interviews, in each country I collected recent publications and statistics about hospital finance. The many publications are cited in the monograph I wrote about each country.

#### MANUSCRIPTS

For each of the first five countries, I wrote a long monograph summarizing the basic facts about its hospital finance. Each chapter ends with some preliminary impressions about lessons for the Americans -- i.e., perspective about common difficulties that are hard to resolve, specific methods to emulate, weaknesses to avoid.

Each volume is issued by the Center for the Social Sciences, Columbia University. Each is written by William Glaser:

|   |                 |
|---|-----------------|
| <u>Paying the Hospital in Switzerland</u>     | (October 1979)  |
| <u>Paying the Hospital in The Netherlands</u> | (February 1980) |
| <u>Paying the Hospital in France</u>          | (August 1980)   |

Paying the Hospital in Canada

(November 1980)

Paying the Hospital in England

(June 1981)

(A separate national monograph was not written about West Germany.)

The present monograph is addressed to the objectives of the grant from HCFA, viz., the experiences abroad that give a deeper understanding of the United States; specific methods abroad that can improve America's response to its problems.

The present manuscript does not attempt to summarize all the facts obtained from all the countries. Such a document would be too long and too prolix. Many details about five of the countries already appear in the monographs previously listed. In a future book, I will try to write a codification of facts about principal themes. The next chapter presents a very short orienting summary of the main characteristics of each country. It also compares them all briefly, by means of a tabular display.

The present manuscript does not follow a simple outline. It picks many leading problems in hospital finance and tells how other countries deal with them. These are separate narratives with considerable overlap.

Most of the research about hospital finance in the United States is econometric, and many readers presume that nothing less is respectable.\* During my work abroad, I collected much statistical data in each country. The aforementioned national monographs cite some of them, as do the following pages in this volume. But this manuscript is primarily an analysis of administrative arrangements. It might be possible to create comparative tabulations of the hospital data from each country, to identify effects of variations in their management practices and financial methods. Studies within individual countries

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\*Actually, on close inspection, much of this work is not as "hard" and "rigorous" as advertised. Often the data are weak, having been collected in "soft" and "subjective" ways. (I will mention the vulnerability of data again in the next chapter.) Much of the current "research" is not about empirical reality but describes how people and organizations would behave if they followed the authors' assumptions. Many publications fail to analyze the dynamics of relationships over appropriate time spans, but are based on a cross-section not conducive to causal inference.

are promising.<sup>10</sup> But comparative statistical inference would require a great effort: data files within each country would have to be standardized as a first step; across countries, sub-samples for the analysis would have to be standardized in representativity and in definitions of units; organizational, financial, and some clinical data would have to be linked, as they usually are not now; separate but comparable tabulations would have to be ordered in each country, since at present the original data files cannot be copied and exported to a central project headquarters. Even a basic comparison of all the hospital data<sup>11</sup> would require a special effort beyond the time available in my project.

The following chapters include summaries of the American situation, as preludes to the foreign practices. Some of these presentations are long. Many differ from the usual literature about American hospital finance, since a goal of cross-national research is to yield new insights into the American situation. From this perspective, I am skeptical of some of the fashionable literature about American hospital finance.

## FOOTNOTES

1. Data about hospital spending in many countries earlier during the 1970's appear in Robert J. Maxwell, Health and Wealth (Lexington, Mass.: Lexington Books, 1981), pp. 82-86.

2. Time series back to the early 1960's are in John R. Coleman and Joseph G. Simanis, "Rising Health Care Costs: A World Problem," Appalachian Business Review, Number 3 (1979), p. 8; in Jean Pierre Poullier, Public Expenditures on Health (Paris: OECD, 1977), pp. 33-35; and in unpublished data from the Health Industries Department, SRI International.

3. Data from the newsletter, Trends: Community Hospital Indicators (Chicago: Office of Public Policy Analysis, American Hospital Association, monthly).

4. The baffling distinctions among costs, charges, and payments by different payers for different types of patients are described in Hirsch S. Ruchlin et al., "Cost of Hospital Care and Third Party Payer Reimbursement," New York State Journal of Medicine, March 1981, pp. 411-415.

5. I have previously described the ways one country can derive lessons from others in William Glaser, Health Insurance Bargaining: Foreign Lessons for Americans (New York: Gardner Press and John Wiley, 1978), Appendix A. During the recent controversy over the Food and Drug Administration's screening of new drugs, the General Accounting Office and others have suggested that FDA adopt methods common in Europe. Comptroller General of the United States, FDA Drug Approval -- A Lengthy Process That Delays the Availability of Important New Drugs (Washington: U.S. General Accounting Office, 1980), pp. 30-44 and 74-76. Lessons from other countries have startled Americans in other fields where competition has serious effects, such as the attention attracted by Ezra Vogel, Japan as No. 1: Lessons for America (Cambridge: Harvard University Press, 1979).

6. Their work is in Craig Coelen et al., A Comparative Review of Nine Prospective Rate-Setting Programs (Washington: Health Care

Financing Grants and Contracts Reports, 1980); and nine monographs describing American state regulatory efforts and Blue Cross arrangements.

7. The purpose is a sequel to William Glaser, Paying the Doctor (Baltimore: The Johns Hopkins Press, 1970).

8. Such field research about the organization and work of government agencies and high-level public organizations has become common. For example, books by Robert Bendiner, Obstacle Course on Capitol Hill (New York: McGraw-Hill Book Company, 1964); Eugene Eidenberg and Roy D. Morey, An Act of Congress: The Legislative Process and the Making of Education Policy (New York: W. W. Norton and Company, 1969); and Hugh Heclo and Aaron Wildavsky, The Private Government of Public Money: Community and Policy inside British Political Administration (Berkeley: University of California Press, 1974). Only one textbook has been written about the methodology: Lewis Anthony Dexter, Elite and Specialized Interviewing (Evanston: Northwestern University Press, 1970).

9. Some criticisms by economists themselves about each other's methods and inferences are Sylvester E. Berkli, Hospital Economics (Lexington, Mass.: Lexington Books, 1972); and Uwe E. Reinhardt, "Comment" (on another paper at a symposium) in Warren Greenberg (editor), Competition in the Health Sector (Washington: Federal Trade Commission, 1978), pp. 156-190. Much more could be said.

10. Examples are the analysis of English data in Martin Feldstein, Economic Analysis for Health Service Efficiency: Econometric Studies of the British National Health Service (Amsterdam: North-Holland Publishing Company, 1967); analysis of Dutch data in J. H. van Aert, Ziekenhuiskosten in econometrisch perspectief (Utrecht: H. E. Stenfert Kroese, 1977) and in several papers by A. P. W. P. van Montfort, National Ziekenhuisinstituut.

11. As in the special research projects by Brian Abel-Smith, An International Study of Health Expenditure (Geneva: World Health Organization, 1967); and Maxwell, op. cit. (footnote 1, supra).

## CHAPTER II

### CHARACTERISTICS OF HOSPITALS AND PAYMENT SYSTEMS

A simple taxonomy of the world's hospital systems is difficult to find. Hardly anyone has attempted to write an overview, and authors get bogged down in detailed variations.<sup>1</sup> A very few books collect separate descriptions of hospitals in several countries.<sup>2</sup> A more manageable effort is to focus on a few themes and generalize about them across several countries, but few researchers have attempted even this.<sup>3</sup>

The national monographs written so far in this research project describe the countries I visited in detail. The following pages are a brief overview, to orient the reader.

#### TOTAL NUMBERS AND UTILIZATION

Table II-1 summarizes the basic facts about the five European countries, Canada, and the United States.

While the United States is very large, several of the other countries are substantial too, viz., France, Germany, and England. The United States has a large number of hospitals, but so do the European countries. Their bed density exceeds America's.

Continental Europe has longer stays and higher occupancy than the United States. The Americans have greater service intensity -- i.e., for each bed, shorter stays, more admissions, and higher turnover. When a country has more admissions and longer stays -- such as Germany and France -- it has more patient-days relative to its population. The three Anglo-Saxon countries have fewer patient-days relative to their populations, because of their shorter stays.

In all countries, except England, hospitals are owned by voluntary associations and local governments. Proprietary hospitals are large in number in France, Germany, and the United States, but they are small in size and handle only a fraction of the patient load.

Table II-1  
Characteristics of Countries

|  | <u>France</u> | <u>Holland</u> | <u>West Germany</u> | <u>Switzerland</u> | <u>Canada</u> | <u>England</u> | <u>United States</u> |
|--|---------------|----------------|---------------------|--------------------|---------------|----------------|----------------------|
| Population (est.)                        | 52,920,000    | 13,853,000     | 61,396,000          | 6,327,000          | 23,316,000    | 46,350,000     | 216,383,000          |
| Year of data                             | 1976          | 1976           | 1977                | 1976               | 1976          | 1977           | 1977                 |
| General (acute hospitals)                |               |                |                     |                    |               |                |                      |
| Total number                             | 3,030         | 238            | 2,185               | 214                | 894           | 922            | 6,322                |
| Owned by government                      | 524           | 27             | 897                 | 113                | 888           | 797            | 2,212                |
| Private nonprofit                        | 337           | 211            | 877                 | 82                 | { } 125       | { } 125        | 3,335                |
| Private for-profit                       | 1,305         | 0              | 411                 | 19                 | { } 6         | { } 6          | 3,775                |
| Beds per 10,000 pop.                     | 57.1          | 51.1           | 79.5                | 57.6               | 54.4          | 37.5           | 49.5                 |
| Admissions per 10,000 pop.               | 1,677.4       | 1,071.1        | 1,511.0             | 1,119.8            | 1,577.5       | 1,041.0        | 1,672.4              |
| Admissions per bed                       | 20.7          | 21.0           | 19.0                | 19.5               | 29.0          | 27.8           | 33.8                 |
| Morbidity (patient-days per 10,000 pop.) | 2,35          | 1.52           | 2.14                | 1.61               | 1.50          | 1.15           | 1.34                 |
| Occupancy, in %                          | 79.6          | 84.4           | 82.6                | 76.2               | 76.2          | 72.0           | 73.7                 |
| Average length of stay                   |               |                |                     |                    |               |                |                      |
| In days                                  | 14.0          | 15.3           | 15.7                | 14.3               | 9.6           | 9.5            | 8.0                  |
| All hospitals                            |               |                |                     |                    |               |                |                      |
| Total number                             | 3,566         | 772            | 3,416               | 474                | 1,389         | 2,250          | 7,234                |
| Owned by government                      | 1,035         | 772            | 1,258               | 199                | 1,299         | 2,125          | 2,641                |
| Private nonprofit                        |               |                | 1,141               | 207                | { } 90        | { } 90         | 2,641                |
| Private for-profit                       | 1,722         | 0              | 1,017               | 68                 | { } 1,228     | { } 1,228      | 3,618                |
| Beds per 10,000 pop.                     | 68.3          | { } 123.6      | { } 61.9            | 71.4               | 84.6          | 82.7           | 25.9                 |
| Owned by government                      | 13.4          |                | 41.5                | 34.7               | 17.9          | 7.2            | 32.8                 |
| Private nonprofit                        |               |                | 14.3                | 8.5                |               |                | 1.9                  |
| Private for-profit                       | 20.2          | 0              |                     |                    |               |                |                      |
| Admissions per 10,000 pop.               | 1,125.9       | { } 1,135.0    | { } 922.9           | 856.5              | { } 1,659.2   | { } 1,153.0    | 268.2                |
| Owned by government                      | 163.2         |                | 631.8               | 416.2              | 96.3          |                | 1,355.8              |
| Private nonprofit                        | 516.3         | 0              | 155.9               | 119.8              |               |                | 143.5                |
| Private for-profit                       |               |                |                     |                    |               |                |                      |

## NOTES TO TABLE II-1

Sources: My calculations from statistical publications in each country. Many of them are cited and the information reproduced in World Health Statistics Annual (Geneva: World Health Organization, 1980), Volume III.

Blank spaces mean that the data were not separately run for those categories. Some categories are combined in the data files in some countries: for example, Holland has so few governmentally owned hospitals, that the data are always merged with the voluntary hospitals'; England has so few private hospitals that the nonprofits and for-profits are always combined.

Data in Canada always combine hospitals, regardless of ownership. After a search in directories, I identified 338 general hospitals with 30,406 beds owned by municipal, provincial, and national governments. 510 general hospitals with 94,389 beds were owned by religious groups and voluntary associations.

Data are for England alone and do not include Scotland, Wales, or Northern Ireland.

## OWNERSHIP AND MANAGEMENT

The principal forms of ownership in the world are:

1. Voluntary associations, churches, and religious orders. Once they owned nearly all hospitals in Europe and North America. They still own most, but for the exceptional countries (France and Great Britain), where government took them over.
2. Government:
  - (a) National. The National Health Service makes Britain the only Western country with nearly exclusive ownership of hospitals by the national government. Before 1946, the hospitals were owned by voluntary associations and local governments, but the bankruptcy of the financing system required greater government intervention. The medical profession pressed to take all out of the hands of local governments.
  - (b) Local. If a country has one or more waves of anti-clericalism and expropriation of Church property, most of its hospitals fall into the hands of local governments. Examples are France and Italy, although the latter still has many Church-owned establishments. Local government ownership on a substantial scale evolves gradually in every country, to fill gaps left by the voluntary associations and churches. Government hospitals have the advantage of more money for investment than the voluntaries.
  - (c) Regional. In federal systems, provincial governments own the public universities and therefore they own the teaching hospitals. Examples: Germany, Switzerland, parts of Canada, and (in many cases) the United States. Provincial governments often own the principal mental hospitals.
3. Private individuals and companies:
  - (a) Physicians. The small "private clinic" with a few beds for private persons once was very common throughout Europe and the United States. It has steadily diminished. A few large proprietary hospitals owned by single doctors exist in Germany.

- (b) Partnerships of several doctors. Some attain sufficient scale to be accepted under health plans and national health insurance. If so, they can survive.
- (c) Business firms owned by physicians. They arise and survive only in a few countries, most conspicuously in the United States.

Hospitals can be coordinated in a nation-wide system even with mixed local, nonprofit, and private ownership. Examples are France and Italy.

Within the hospital, the medical director has nearly disappeared. In every Western country, the hospital is directed by a layman who has graduated from courses in health administration. The medical director survives in countries with many doctors and vertical bureaucracies (such as the Soviet Union), where the doctor rises in his career by moving into executive positions.

Except in countries with national health services (such as Great Britain and the Soviet Union), every hospital usually has its own governing board. Its legal authority and political skill enable the typical hospital to operate quite autonomously, even if in theory it is owned by the local government.

#### FINANCING

##### Sources of money:

1. National health insurance is the common method in Europe. Payroll taxes are levied on workers and employers and are paid into special sick funds. Government pays the premiums of the elderly. The funds pay the hospitals and doctors.
2. Government revenue:
  - (a) Common for construction and heavy equipment.
  - (b) Unusual for patient care. Adopted only if national health insurance proved inadequate financially (Great Britain and Italy) or if it was never tried and private insurance was inadequate (Canada).

3. Private insurance, including nonprofit. The Netherlands is the only European countries with a substantial number of persons not covered by NHI; nearly all these persons have private policies. The United States is the only developed country without NHI on a large scale; it has a mixture of different nonprofit and private policies. (The American mixture includes a kind of small-scale NHI for the aged and revenue-supported charity care for the poor.)
4. Cash payments by patients. Once common, but now rare in all countries, except for extra benefits. Health insurance evolved to enable patients to pay, and the sick funds then became third parties, paying hospitals directly. Cash payments for part or all of the fees are still common in the payment of doctors in a few countries, such as the United States and Belgium.
5. Charitable donations. Once common for investments and operating costs in all countries. Has now disappeared almost everywhere, except for some gifts of buildings and equipment for special programs. In the absence of general public financing and national health insurance, many American hospitals still depend on donations, even for shortfalls in their operating budgets.
6. Reinvestment of profits. In the past, hospitals in many countries had endowments of land, buildings, vineyards, orchards, etc. The fortunate ones could pay for much of their operations from rents and from sales of merchandise. Periods of inflation, depression, and wars have forced most to sell their valuable properties; or, the yields did not keep up with the growing magnitude of hospital operations. Not many foreign hospitals still have profitable endowments, but a few do.

For hospitals to earn profits from the mainstream of national health insurance or governmental payments is not possible abroad. A few proprietary hospitals earn profits, but they have private clienteles. Rate regulators from government and negotiators from sick funds abroad never allow profits; their calculations cover the hospital's costs and no more. The United States is the only country allowing proprietaries a profit and allowing the nonprofits

a return on capital under the principal health insurance and the principal public grants for operations.

How the hospital's revenue is decided:

1. Hospital sets its own charges. Once this was the rule, but it is unrealistic today, when every country has one or several organized payers, when governments intervene on behalf of the public interest to prevent waste, profiteering, and fraud. The United States is the only country where the hospital manager comes close to setting his own budget and price schedules: in most American states, he faces separate, organized payers and is constrained over each arrangement, but the manager has discretion over certain prices and over the total mix.
2. Adversarial bargaining between the individual hospital (backed up by the provincial or national hospital association) and all organized payers forming a team. While the standard method for determining the contracts and fees of office doctors, bilateral negotiation in hospital finance is unusual. It exists for all hospitals in West Germany and for the proprietary hospitals in France. In limited form, such bilateral negotiation sets the contracts and rates between America's Blue Cross and individual hospitals.
3. Screening agency that represents all the hospitals and all the sick funds. This arrangement replaces bilateral negotiation between hospitals and sick funds, which founder on the sick funds' lack of staffing and expertise. The screening agency is both expert investigator and arbitrator. An example is COZ in The Netherlands, which also can function as a government regulatory commission, under some circumstances. A few such joint commissions exist in French-speaking Switzerland, but with wider scope, since they involve the cantonal governments as well. A few American committees created either by the hospital association or by Blue Cross behave a bit like this, as in Michigan and Indiana.
4. Government regulation of hospital budgets and rates:
  - (a) Agencies of government. For example, France and some American states, such as New York and New Jersey.

- (b) Independent commissions. Peculiar to the United States, with its suspicion of politicians and fear that line agencies can be captured by one side. Examples are Maryland and the state of Washington.
5. Government pays hospitals their operating costs and sets the amounts. Hospitals may initiate requests; or government may allocate its available money among hospitals without reviewing the hospital managers' requests first. In either case, the final word is determined by interaction between the Treasury and the Ministry of Health. Examples are Britain, Canada, and Italy. The cantonal governments of Switzerland decide the shares of the hospital budgets coming from the sick funds and their own public budgets.

The units of payment are:

- 1. Global budget, the entire amount for operating costs during the coming year. The usual method when government pays all or nearly all the hospital's revenue. Payments are made in twelve or twenty-four installments. Examples are Britain and Canada. In Britain, the budgets are successively subdivided on each tier of the National Health Service; the hospital is one of several entities with parts of the total district budget. In Canada, each hospital gets a distinct budget from the provincial Ministry of Health.
- 2. Daily charge. A hospital is paid for the number of days of a patient's hospitalization multiplied by the standard daily charge averaged over all patients. In some form, this is nearly universal for basic ward care in countries with health insurance and direct payments by or on behalf of the patient. It has existed for nearly a century in most, even longer in a few.
  - (a) All-inclusive, including physicians' salaries. Standard for all services in the hospital. Example is West Germany, except in its proprietary hospitals and in its smaller hospitals.
  - (b) All-inclusive except for physicians' fees, which are paid separately by sick funds according to fee schedules negotiated

with the medical association. Example is the Netherlands.\*

Most European proprietary hospitals have this arrangement, since the physicians are not salaried.

- (c) All-inclusive, including physicians' salaries, but with separate rates for the principal clinical services. This requires the hospital's finance office and the rate regulators to break the total prospective budget into cost centers. Example is France.

3. Itemized. Never done completely in any foreign country, but some wide deviations from the daily charge exists. For example, Swiss hospital bills distinguish basic average daily charges (a) for basic nursing and medical care and (b) for housing and food. Some hospitals (particularly the proprietaries) break certain clinical items out of the basic daily charges and bill for them separately, such as use of the operating room, drugs, medical supplies, physiotherapy, and physicians' fees. If a patient gets a first-class or second-class room and special amenities, these are billed separately in every country.

The American hospital bill for each patient usually lists separately the basic daily charge, charges for many clinical services ("ancillary services"), and many extra amenities, often to earn revenue. (Usually the attending doctor sends his own separate bill.) Such extensive itemization is unusual abroad, even in proprietary hospitals. Where Blue Cross Plans have large numbers of patients and use cost reimbursement, the ancillary use by all their members may be averaged, a per diem use of the ancillaries is

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\*Such a method could be a windfall for the hospital doctors, since they would be paid according to a fee schedule negotiated between the medical association and the sick funds to cover the practice costs of office doctors as well as the honoraria for their personal incomes. The Dutch solution is three schedules: the honoraria for physicians, paid by the sick funds to the hospital doctors on receipt of their bills; a list of costs to the hospital for each act performed by hospital doctors where the sick funds will pay the honorarium part to the doctor directly (the Tarievenlijst); and a daily rate for all other hospital costs. The hospital using "all-out" billing asks from the sick fund for each patient the daily rate plus the items on the Tarievenlijst.

calculated, and it is added to the basic daily charge to produce a more inclusive payment per patient-day -- i.e., the hospital sends an itemized bill for each patient but gets from Blue Cross an all-inclusive per diem.

4. Case payments. Rates vary by diagnosis. An American idea, at present practiced experimentally only in New Jersey and Maryland. Variations in time perspective, associated in practice with per diem payments:
  1. Guaranteed reimbursement of costs. An interim rate is paid during the year. It is updated several times. At the end of the year, a full expenditure report is calculated by the hospital and audited by the third party, supplements are paid to make up deficits, or the hospital pays back surpluses.
  2. Prospective charges. At the start of the time frame, the hospital and third party agree on a schedule of charges. All patients are paid for according to the schedule until a new one is adopted.

#### MEDICAL STAFFS

Doctors decide the utilization and level of costs of hospitals. How they are organized is fundamental to the structure and financing of the hospital more generally.

1. Extent of staff privileges
  - (a) Closed staffs. Usually only a specified group of doctors has admitting and treatment privileges in hospitals. During the twentieth century in most of the world's cities, the distinction has produced two classes within medicine: the hospital specialties with a monopoly on teaching and on remunerative advanced care; the office doctors, confined to simpler care in ambulatory settings or in private clinics.
  - (b) Open staffs. Literally, this would mean that any qualified physician can admit and treat in the locality's hospitals. This has always been true throughout the world in rural areas and in small towns, places without specialists. In its familiar spirit of open opportunity, the United States permitted

open staffing in many city hospitals too. Recently, problems of quality control and administrative order have produced a compromise in the United States: many office doctors are screened and approved as "attending" or "courtesy physicians," the less impressive in a community may not win a hospital affiliation, but the hospital is led by an inner core of specialists. The result still makes American hospital organization more amorphous than any foreign one, and more office doctors are able to do specialized work.

2. Time devoted to the hospital:

- (a) Part-time. Once no senior doctor spent all his time inside the hospital. He saw a few patients, taught students, and managed his service for a few hours at a nominal salary, and he spent most of his day in private practice in his office and private clinic. The trend in every country has been toward full-time salaried practice for the seniors as well as for the juniors. Part-timers are still found in Europe among the office doctors who work in local hospitals in rural areas and small towns. Some medium-sized European hospitals lack the work load for a full-timer in certain specialties (orthopedics, ENT, ophthalmology, etc.), and they sign local specialists to part-time contracts. The United States is the only country where the typical hospital doctor still spends most of his time outside, seeing only his own patients and a few others inside.
- (b) Full-time. In recent decades in almost every country, the hospital system has stabilized its organization by persuading its senior doctors to stay on the grounds all the time. to do so, the government and sick funds have had to agree to very high pay and also limited rights of private practice within the hospital. Junior doctors have always been full-time salaried.

3. Service structure:

- (a) Hierarchical. A common pattern is a service headed by one chief; under him is a hierarchy of juniors. Another specialist

may be affiliated, using terminology that makes him sound like the chief's colleague and not a subordinate. Most countries have this arrangement.

- (b) Egalitarian. Within a service are several coequal specialists. Each has his own subordinate group of juniors and very clear jurisdiction, such as his own set of beds and patients. An example is Britain.
- (c) Diffuse. The hospital on paper may have several services with full-timers administering their clinical aspects. But many other doctors -- full-time or part-time -- are affiliated. An example is the United States. Or, the departmental structure itself is not clear. An example is the Netherlands.

4. Pay:

- (a) Fee-for-service. Once all senior doctors earned most of their income from fees, in private practice and under national health insurance. Senior hospital doctors got small salaries but earned most of their incomes from fees outside. Doctors in offices and in proprietary hospitals still earn fees, both from patients' health insurance and from their out-of-pockets. But other hospital doctors rely less on fees nowadays. Some full-time senior hospital staffs, however, are still paid by fee-for-service. Examples are The Netherlands and Canada. American attendings are still paid by fee-for-service.
- (b) Salaries. A trend has been toward full-time hospital affiliations in almost every country, and usually (not always) this has involved full-time salaries. The salaries are counted in the comprehensive daily charge or global budget collected by hospitals from sick funds and governments; but fees usually mean that the doctor bills the sick funds directly, without a role for the hospital. Often the salaried arrangements forbid private fee-earning practice (as in France and Sweden), but sometimes the specialist may see private patients too for fees (as in Germany).
- (c) Percentage of receipts. Once many American radiologists and pathologists collected a proportion of the earnings of their

departments from itemized billing. No other country has ever used this method. It has rapidly declined in the United States because Medicare has preferred paying all doctors by fee-for-service.

#### OVERVIEW OF ORGANIZATIONS AND PAYMENT SYSTEMS

Following are a summary and comparison of the methods of organizing and paying hospitals in the six foreign countries studied in depth during this research. The following should obviate the need for descriptive summaries of each country in this volume.

The United States can be included in aggregate statistical counts, as in Table II-1, but not in simple cross-national institutional descriptions, like the following. It cannot because of a central theme in this research. Every other developed country has certain general patterns in the management and finance of hospitals. But the United States has none: every payer follows different practices; every state has somewhat different ground rules.<sup>4</sup>

Abbreviations in the following array:

DNA = Does not apply, since the payment system  
operates on different principles

NHI = National health insurance, rather than  
private insurance

NHS = National health service run by government

FTE = Full time equivalents, when counting numbers  
of employees

|  | Holland   | West Germany                                     | Switzerland  | Canada                                      | Great Britain NIS                 |
|--|---|--|--|---|-----------------------------------|
| <b>Program characteristics:</b>                            |   |  |  |   |                                   |
| Coverage of population                                     | Complete under NHI<br>Extensive for cost-sharing                | 70% under NHI<br>About 30% under commercial      | 90% under NHI<br>About 9% under commercial         | 94% under various programs                  | Complete                          |
| Benefit coverage standard for all                          | Yes   | Yes to those covered by NHI                      | Yes to those covered by NHI                        | Yes for basic; supplemental coverage varies | Yes                               |
| Number of payers   | Very few, one principal   | One or few in each area                          | Several in each area                               | In most cantons, several                    | One per province                  |
| Principal revenue source for insurance or benefits program | Payroll taxes   | Payroll taxes                                    | Subscriber and employer premiums                   | General revenue in most provinces           | General revenue in most provinces |
| General Treasury payments to each hospital                 | No  | No   | No   | Yes, in part                                | Yes, almost in full               |
| General Treasury payments to sick funds                    | Begins recently   | Yes  | No   | Yes   | DNA                               |
| Out-of-pocket payments for benefits in basic package       | Few   | No for NHI<br>Yes for some commercial            | No for NHI<br>Yes for some commercial              | Some  | Few                               |
| <b>Decision-making methods:</b>                            |   |  |  |   |                                   |
| System used  | Public: rate regulation<br>Private: negotiation with sick funds | Rate regulation                                  | Negotiation with sick funds                        | Mixture in each canton                      | Government grants                 |
| Where regulation is used:                                  |   |  |  |   | Legislation and administration    |
| Source of guidelines                                       | National government, commissions                                | National government, if appeal from negotiations | Provincial government, if appeal from negotiations | Cantonal government                         | DNA                               |
| Rates fixed by   | Local civil servants representing national government           | Autonomous commission                            | Provincial government, if negotiations fail        | Cantonal Ministry of Health                 | DNA                               |
| Control over regulatory system                             | Elected government  | Interest groups and government                   | Elected government                                 | DNA   | DNA                               |
| Some hospitals exempt in practice                          | No  | Very few   | No   | DNA   | DNA                               |

|   | France  | Holland   | West Germany                        | Switzerland  | Canada   | Great Britain NHS                   |
|---|---|---|-------------------------------------|--|--|-------------------------------------|
| Hospital association represented in approval of guidelines                  | No  | Yes   | Yes                                 | No in most cantons<br>Yes in a few                               | DNA  | DNA                                 |
| Public authority discusses rates or grants with hospital before final award | Yes   | Yes   | Yes, after arbitration              | Yes  | Yes in most provinces;<br>no in Ontario                      | DNA                                 |
| Where government grants hospital part or all its budget:                    |   |   |                                     |  |  |                                     |
| Level of government   | DNA   | DNA   | DNA                                 | Province   | Regional subdivision of national government                  | General revenue                     |
| Source of money   | DNA   | DNA   | DNA                                 | General revenue  | General revenue; a few premium systems                       | General revenue                     |
| Appeals procedure   | External  | External  | External                            | None   | Internal   | None                                |
| Form of review by public authority:   |   |   |                                     |  |  |                                     |
| Prospective review of budget  | Line-by-line  | Line-by-line  | Line-by-line                        | Line-by-line   | Once line-by-line; trend toward general categories or global | Global, general categories          |
| Retrospective monitoring  |   |   |                                     |  |  |                                     |
| Payers coordinate with investment planners                                  | Line-by-line<br>CRM, a little                                       | Line-by-line<br>No  | DNA                                 | Line-by-line   | Mixed  | Line-by-line                        |
| Regulators coordinate with investment planners                              | DBASS, a little   | No  | No                                  | Yes, where cantonal government                                   | Yes, identical   | Yes, identical                      |
| Wage rates decided by   |   |   |                                     |  |  |                                     |
| Public authority (regulators or grantors) approve new hiring by hospital    | Public: national civil service<br>Nation-wide collective bargaining | Public: national civil service<br>Non-public: nation-wide collective bargaining | Cantonal civil service governs many | Individual bargaining in some provinces; province-wide elsewhere | Nation-wide collective bargaining                            | Bed-FTE guideline in some provinces |
|   | Only general ceilings   | Bed-FTE guideline   | DNA                                 | Specific approvals in some cantons                               | Only general expenditure ceilings                            |                                     |

|   | France                          | Holland              | West Germany | Switzerland                     | Canada         | Great Britain NHS  |
|---|---------------------------------|----------------------|--------------|---------------------------------|----------------|--|
| <u>Payment method:</u>                                  |                                 |                      |              |                                 |                |  |
| Basic unit  |                                 |                      |              |                                 |                |  |
| Public: daily rate                                      | Daily rate                      | Daily rate           | Daily rate   | Daily rate plus budget          | Budget         | Budget   |
| Private: daily rate, some items                         |                                 |                      |              |                                 |                |  |
| Differentiated by:                                      |                                 |                      |              |                                 |                |  |
| Type of service   | Yes                             | No                   | No           | No                              | No             | No   |
| Type of patient   | No                              | No                   | No           | No                              | No             | No   |
| Orientation   | Prospective                     | Prospective          | Cost         | Cost                            | Prospective    | Prospective  |
| Base of payment   | Public: cost<br>Private: charge |                      |              |                                 |                |  |
| Additional charges for items                            |                                 |                      |              |                                 |                |  |
| Hospital can choose among alternative formulae or rates | Public: no<br>Private: yes      | Some hospitals       | No           | Yes for a few private hospitals | No             | No   |
| Annual increase:  |                                 |                      |              |                                 |                |  |
| Automatic across-board, in %                            | No                              | Yes                  | No           | Not in past, possibly in future | No             | No   |
| Individualized, according to budget                     | Yes                             | Special applications | Yes          | All                             | Some provinces | Yes, according to government's judgment of hospital's programmatic needs |
| Regulation extends to private room rates                | Yes                             | No                   | Yes          | No                              | No             | Yes  |

|   |                             |                             |                                   | Great Britain NHS                       |
|---|-----------------------------|-----------------------------|-----------------------------------|---|
|   |                             |                             |                                   | Canada                                  |
|   |                             |                             |                                   | Switzerland                             |
| <u>Uniformity or variations:</u>                          |                             |                             |                                   |   |
| Price discrimination among insured persons                | Not in same hospital        | Not in same hospital        | No                                | DMA                                     |
| Different hospital systems with different payment methods | Yes, public-private         | No                          | No, but diverse owners            | No                                      |
| Self-payer same as insured                                | Yes                         | Yes                         | No, but diverse owners            | No                                      |
| Regional variations in the system                         | None                        | Provincial                  | Treasury share varies by province | Regional and Local administrative units |
| Allowable costs vary by program                           | No                          | No                          | No                                | DMA                                     |
| Difference between acute and chronic                      | Yes                         | No                          | Yes                               | Yes                                     |
| Out-of-jurisdiction patients pay more                     | No                          | No                          | No                                | No                                      |
| Cross-subsidization among services                        | Public: yes<br>Private: yes | DMA, one hospital-wide rate | DMA, one hospital-wide rate       | DMA, global budget                      |
| Hospitals free to charge private patients without limit   | Public: no<br>Private: yes  | Yes                         | Yes, in theory                    | No                                      |

|  | France  | Holland                           | West Germany                      | Switzerland                  | Canada                      | Great Britain NIS           |
|--|---|-----------------------------------|-----------------------------------|------------------------------|-----------------------------|-----------------------------|
| <u>Costs allowable in payment to hospital:</u> |   |                                   |                                   |                              |                             |                             |
| Purchase and financing of building             | Yes   | No                                | No                                | No                           | No                          | No                          |
| Purchase of equipment depreciation             | Yes   | Only minor                        | Varies by canton                  | Only minor                   | Only minor                  | Only minor                  |
| Interest charges                               | Yes   | No                                | Usually no                        | No                           | No                          | No                          |
| Last year's deficit                            | Yes   | Yes                               | Usually no                        | No                           | No                          | No                          |
| Doctors' earnings                              | Public: yes<br>Private: rarely  | Yes                               | No                                | No                           | No                          | No                          |
|  | Public: yes<br>Private: no  | No                                | Yes, salaries                     | Some yes, some no            | No                          | Yes                         |
| Educational costs for:                         |   |                                   |                                   |                              |                             |                             |
| Doctors  | Yes   | Mixed                             | No                                | Only some                    | Yes                         | Yes                         |
| Nurses   | Yes   | Yes                               | Yes                               | Only some                    | Yes                         | Yes                         |
| Wage passthrough                               | Public: yes<br>Private: no  | Yes                               | Yes                               | Yes                          | Usually yes                 | Yes                         |
| Bad debts                                      | Yes   | No                                | No                                | No                           | Yes                         | No                          |
| Outpatient costs                               | Public: some<br>Private: no   | No                                | Yes*                              | Yes, under subsidy by canton | Yes                         | Yes                         |
| Constraint on utilization as part of the award | Public: yes, but not systematic<br>Private: no                                    | No                                | No                                | No                           | Some provinces yes, some no | Yes, because of cash limits |
| Cost-sharing by patient                        | Public: yes,<br>part of charge<br>Private: yes,<br>in addition to official charge | NHI: No<br>Privately insured: yes | NHI: No<br>Privately insured: yes | Yes                          | No                          | No                          |

|  | Holland                      | West Germany  | Switzerland            | Canada                    | Great Britain NHS                                    |
|--|------------------------------|---|------------------------|---------------------------|--|
| Reporting and accounting:  |                              |   |                        |                           |  |
| Uniform internal hospital accounts   | Yes                          | No  | Yes                    | Yes                       | Yes  |
| Uniform report to regulators or grantors                                       | Yes                          | Yes   | Yes                    | Yes                       | Yes  |
| Are the foregoing two the same   | Yes                          | No  | No                     | No                        | Yes  |
| Nation-wide uniformity Int:  |                              |   |                        |                           |  |
| Internal hospital accounts   | Yes                          | No  | Yes                    | Yes                       | Yes  |
| Report to regulators or grantors   | Yes                          | Yes   | No                     | No                        | Yes  |
| External expenditures audit is reviewed by regulator or grantor                | Yes                          | No  | Yes                    | Yes                       | Yes  |
| Regulator or grantor prescribes and examines carefully reports on:             |                              |   |                        |                           |  |
| Interim expenditures   | No                           | No  | No                     | Yes, in many countries    | Yes  |
| End-of-year expenditures   | No                           | No  | No                     | Yes                       | Yes  |
| Reporting by clinical department   |                              |   |                        |                           |  |
| Cash flow:   |                              |   |                        |                           |  |
| Handling of patient costing-sharing  | Separate billing by hospital | NHl: DNA<br>Private: cash benefits system in theory | Collected by sick fund | DNA                       | NHS: DNA<br>Private:<br>separate billing by hospital |
| Administrative costs of billing:   |                              |   |                        |                           |  |
| For sick fund  | Great                        | Some  | Some                   | Some                      | Almost none  |
| For hospital   | Great                        | Low   | Some                   | Some                      | Almost none  |
| Speed of payment   | Slow                         | Quick   | Quick                  | Automatic<br>Installments | Automatic<br>Installments                            |
| Medical staffs organized to participate in financial decision in each hospital | Yes                          | No  | No                     | No                        | No   |
| A "profit" can be retained by the hospital                                     | Occasionally                 | Public: no<br>private: yes                          | Yes                    | No                        | No   |

## PERSONNEL

Since hospitals are labor-intensive, a crucial cause of differences among countries in costs is variation in their staffing. Hospitals are more expensive in the United States because they employ more people.

The difference is not so great in the sheer number of doctors, working in hospital staffs, in office practice, and in the peculiar American arrangement of office practice with hospital privileges. Once the United States had more doctors relative to its population than nearly any other country. Medical education then expanded and modernized during the 1960's and 1970's in all countries, more extensively abroad than in the United States, because America retained its custom of small and select entering classes, manageable for intensive clinical preparation. Between 1960 and 1975, doctors per 10,000 population increased 25 per cent in the United States but more in every other developed country. For example, 29 per cent in West Germany, 37 per cent in The Netherlands, 46 per cent in France, and 49 per cent in Canada.<sup>5</sup> The current levels are in the upper half of Table II-2.

In the hospital-based occupations, the United States has trained and employed more people. In total numbers of nurses relative to their populations -- both those still working and those who have dropped out -- the United States has more than any other country except Canada. (Many of the Canadian and British nurses are immigrants, as are some Americans.) The figures are in the lower half of Table II-2.

The United States -- and Canada to a slightly lesser extent -- employ more people within the hospital, according to Table II-3. Hospital costs results in large part from the combination of numbers of employees and their wage levels. Therefore, in Table II-3, the higher the number of persons employed in a country's hospitals, the higher the daily costs.

Other researchers have noticed that American hospitals have larger staffs than European, and a few have attempted to identify results. American staffing permits more clinical work in a short time, shorter stays, and more record-keeping.<sup>6</sup> These functional

characteristics are causes as well as consequences of the higher staffing. American hospital utilization differs somewhat from Europe's, with many short stays requiring much activity in a brief period, such as diagnostic workups. American hospitals have more technology for both testing and treatment and -- until the new attempts at multi-hospital sharing -- it brought a steady flow of new technicians into each hospital. America's more open clinical staffing, more complicated hospital financing, and itemized payment of doctors require much more record-keeping.<sup>7</sup>

Table II-2  
Number of Doctors and Nurses

|                              | <u>France</u> | <u>Holland</u> | <u>West Germany</u> | <u>Switzerland</u> | <u>Canada</u> | <u>England and Wales</u> | <u>United States</u> |
|------------------------------|---------------|----------------|---------------------|--------------------|---------------|--------------------------|----------------------|
| Population                   | 52,890,000    | 13,853,000     | 61,396,000          | 6,327,000          | 23,316,000    | 49,119,900               | 215,118,000          |
| Year of data                 | 1976          | 1977           | 1977                | 1977               | 1977          | 1977                     | 1976                 |
| Doctors                      |               |                |                     |                    |               |                          |                      |
| Total number                 | 83,306        | 23,769         | 125,174             | 12,715             | 41,398        | 74,500                   | 361,443              |
| Population per doctor        | 613           | 583            | 490                 | 498                | 563           | 659                      | 595                  |
| Doctors per 10,000 people    | 16.3          | 17.2           | 20.4                | 20.1               | 17.8          | 15.2                     | 16.8                 |
| Nurses and midwives          |               |                |                     |                    |               |                          |                      |
| Total numbers                | 221,955       | 33,826         | 196,833             | 25,600             | 140,000       | 145,393                  | 961,000              |
| Qualified                    | 90,720        | 18,150         | 45,079              | 4,400              | 41,000        | 59,380                   | 488,000              |
| Assistant, practical         | 165           | 267            | 254                 | 211                | 125           | 240                      | 148                  |
| Population per nurse         |               |                |                     |                    |               |                          |                      |
| Population per 10,000 people | 55.1          | 37.5           | 39.4                | 47.4               | 77.6          | 41.7                     | 67.4                 |

Source: World Health Statistics Annual (Geneva: World Health Organization, 1980).  
The nurses in Britain are only those employed by the National Health Service.

Table II-3  
Comparisons in Staffing and Costs

| <u>Country</u> | Hospital employees per 100 beds | Cost per patient-day<br>In original currency | Cost per patient-day<br>Converted to U.S. \$ | Year of data |
|----------------|---------------------------------|--|--|--------------|
| U.S.A.         | 237.5                           | \$194.34                                     | \$194.34                                     | 1978         |
| Canada         | 206.6                           | \$147.92                                     | \$131.60                                     | 1978         |
| Switzerland    | 184.5                           | Fr. 266.85                                   | \$144.24                                     | 1978         |
| Netherlands    | 155.2                           | 312.01 fl                                    | \$139.91                                     | 1978         |
| France         | between 116.5 and 187.1         | between 378.2 F and 620.1 F                  | between \$84.04 and \$137.80                 | 1978         |
| West Germany   | 73.1                            | 168.52 DM                                    | \$81.41                                      | 1978         |

Note:

All data are for acute general hospitals. Because of their open-staff structures, American and Canadian personnel figures do not include the many attending physicians.

French acute hospitals manage extended care facilities and homes for the elderly, and many data are combined. It is not possible to isolate personnel data and total patient care costs for the entire country for the acute hospitals alone. The employees per 100 beds are 116.5 if all beds are counted in the denominator of the fraction, and 187.1 if only the acute and long-stay beds are counted. The cost per patient-day are 378.2 F if all patient-days are counted (including the homes for the elderly) in the denominator of the fraction, and 620.1 F if they are not included.

Except for the medical, nursing, and technical employees, personnel data cannot be isolated for acute hospitals in England. The many ancillary workers are assigned to all the services in the District Health Authority.

My calculations from the following sources:

The United States: Hospital Statistics: 1979 Edition (Chicago: American Hospitals Association, 1979).

Canada: unpublished data from the Institutional Statistics Section, Health Division, Statistics Canada. All public general and allied special hospitals. To estimate number of FTE's, I have counted all the full-timers and have counted each part-timer as if he were half-time.

Switzerland: Jahresbericht 1979 (Aarau: VESKA, 1980).

Netherlands: Statistiek personeelssterkte 1978 and Financiële statistiek 1978 (both Utrecht: National Ziekenhuisinstituut, 1979).

France: Danielle Douxami, "Statistique annuelle des hôpitaux généraux publics de France métropolitaine," Santé, Sécurité, Sociale: Statistiques et Commentaires, Number 5 (Septembre-Octobre 1979), esp. pp. 137-142; and M. Duriez, La consommation médicale finale 1979: Evaluations provisoires (Paris: CREDOC, 1980), esp. pp. 5 and 12.

West Germany: Bundeminister für Jugend, Familie und Gesundheit, Daten des Gesundheitswesens (Stuttgart: W. Kohlhammer, 1980), pp. 233, 249, and 272.

Conversion into U.S. dollars at the free market exchange rates prevailing at the end of June 1978. \$1 (US) = \$1.24 (Canadian) = 1.85 Sfr = 2.23 fl = 4.50 F = 2.07 DM. Source: Pick's Currency Yearbook 1977-1979 (New York: Pick Publishing Company, 1981).

## TOTAL SPENDING FOR ENTIRE COUNTRIES

Nowadays it is common to describe the economic activities of entire countries by figures supposedly aggregated from the reports of all participants. Relations among economic sectors are set forth with great statistical elegance, complete with error terms. Trends are described by rates of change, precise to one or more decimal places. Comparisons are made between countries. The same macrostatistical methods used for other economic sectors presumably should yield estimates of health care spending by total and by special purpose.

Several writers have offered estimates of total spending in many countries, trends over time, and proportions of GNP. The most careful effort has yielded the figures reproduced in Table II-4. Other researchers have offered slightly different calculations about the total volumes of spending and the proportions of GNP.<sup>8</sup> A few have attempted to explain proportion of GNP as a function of some other macroeconomic property, such as the country's disposable income.<sup>9</sup>

Table II-4

## Total Expenditures in 1977

| <u>Country</u> | <u>US \$ per head</u> | <u>Percentage of GNP</u> |
|----------------|-----------------------|--------------------------|
| Sweden         | 928                   | 9.8                      |
| West Germany   | 774                   | 9.2                      |
| United States  | 769                   | 9.0                      |
| Switzerland    | 688                   | 6.9                      |
| Netherlands    | 632                   | 8.2                      |
| Canada         | 609                   | 7.1                      |
| France         | 589                   | 7.9                      |
| United Kingdom | 231                   | 5.2                      |

Source: Robert J. Maxwell, Health and Wealth (Lexington, Mass.: Lexington Books, 1981), pp. 35, 38 and 41.

Usually each country's hospital expenditure data are mixed into its total for all health care. Comparative studies usually concern the total. However, the recent study of hospital costs in France isolated the hospital costs in all other developed countries and compared them.<sup>10</sup>

Health expenditures rise in every country, often substantially. Recently international conferences invite contributors from many countries, each tells that his own spending rises very steeply, and everyone returns to his home office with the conviction that costs are "out of control" everywhere and that no-one has found "the answer." Actually, health care costs rise more in one country than in another. The purpose of this research project is to explain some reasons. Some data appear in Table II-5.

Table II-5  
Average Annual Increases in Total  
Health Spending, 1960-1976

| <u>Country</u> | <u>Actual</u> | <u>CPI</u> | <u>Relative</u> |
|----------------|---------------|------------|-----------------|
| Sweden         | 14.42         | 6.21       | 2.32            |
| West Germany   | 14.45         | 3.81       | 3.80            |
| United States  | 10.80         | 4.21       | 2.57            |
| Netherlands    | 17.35         | 5.80       | 2.99            |
| Canada         | 12.18         | 4.46       | 2.73            |
| France         | 14.84         | 5.89       | 2.52            |
| United Kingdom | 13.00         | 7.63       | 1.70            |

Source: Average annual increases in actual expenditures and in consumer prices from Joseph G. Simanis and John R. Coleman, "Health Care Expenditures in Nine Industrialized Countries, 1960-76," Social Security Bulletin, Volume 43, Number 1 (January 1980), p. 6. I calculated the "relative price effect" by dividing CPI into actual expenditures. The statistic shows the increase in health spending beyond the country's general inflation rate.

Macrostatistical comparisons of national health expenditures data should be performed very cautiously -- and econometric inferences using them are vulnerable -- because of the validity and comparability of the data. A complete nation-wide enumeration of anything is very difficult, even in small and orderly countries. Every national census and election tally have errors; the larger and more unstructured the society, the greater the underenumeration. National counts of personnel, facilities, and services in health -- such as those underlying Tables II-1 and II-2, *supra* -- miss some units<sup>11</sup> but are more accurate than national estimates of spending. Expenditure comparisons encounter several difficulties:

1. Total spending is under-reported when there are multiple payers and many private transactions. More of the expenditures are reported in countries with organized and integrated delivery and financing systems, with third-party payment of providers in full. Because of cost reimbursement systems for paying the nonprofit providers and because of tax liability of the for-profit organizations and fee-earning individual practitioners, health care providers are biased to overstate their costs and conceal their revenue.

Accurate cross-national expenditure comparisons involving the United States founder because of under-reporting. Official reports depend on the statistics from a few organizations (the American Hospital Association, Blue Cross and Blue Shield, the Internal Revenue Service, and a few others), whose respondents overlook some costs by error and some revenue by bias.<sup>12</sup> Conventional health care that is out-of-pocket in the United States (such as dentistry, drugs, and optometry) are reported less fully in America than in countries with full coverage and therefore with full reporting -- i.e., under a National Health Service (such as Great Britain) or under national health insurance (such as Germany). Some large but unorthodox categories of health care -- such as osteopathy in the United States -- are often omitted.

2. Definitions of health care expenditures vary among countries and the macrostatistical comparisons up to now do not standardize them. Some effects are substantial. For example, clinical education is

included in medical expenditure in many countries in full, in some countries in part, and in others (such as the United States) very little.

Some unusual forms of care are counted in some countries, but not in others. The very extensive use of spas are included in German health expenditure and are an important reason German spending seems so high.

Borderline definitions are not standardized. The high administrative costs of the health insurance carriers are usually included in Germany; the lower administrative costs of other countries are handled variously, included in some (such as France) and excluded in others (such as Switzerland). Dutch voluntary welfare associations perform a mixture of health and social services -- for example, for the elderly and handicapped -- and health is defined broadly to include spending that is not counted elsewhere.

3. Measures of the general economy -- often used in the health care statistics -- are not identical among countries or free of error. For example, the CPI varies among countries in composition: America's is sensitive to items that fluctuate widely (such as purchase of new housing), while Germany's is much less sensitive. (The American CPI will be reconstructed during the early 1980's, necessitating a recalculation of the entire time series.) That favorite denominator in much health care expenditure analysis -- GNP -- is not calculated in the same way everywhere and is subject to the same reporting errors (and subsequent corrections) as health care spending. A considerable and prolonged effort had to be mustered among the statistical services of the Common Market to achieve greater uniformity in the calculation of GNP and of other basic economic measures. Still not yet implemented are proposals for harmonization of the health expenditure accounts.<sup>13</sup>

Therefore, I suspect that health spending relative to GNP is really higher in the United States and lower in West Germany than it appears in the statistics quoted in Table II-4, *supra*, and in many other sources. American health spending relative to CPI may have been rising faster than is supposed. the macroeconomic trend analyses and

projections -- which have become the staples of leading American policymakers and researchers during the 1970's and early 1980's -- are unreliable.\*

The composition of health expenditures should be an important idea to measure and compare -- e.g., to identify the systems that do more of their clinical work extramurally and, presumably, with less expense and with less disruption of patients' lives. But the available data -- an example is in Table II-6 -- are elusive. Only in Britain and Sweden do the aggregate accounts clearly distinguish between intramural and ambulatory office care. In all other countries, the proportions for hospital work are underestimates, since much of the earnings of senior hospital doctors is mixed into the totals for office doctors.

#### SUMMARY OF TRENDS

Even though the precise numbers should be questioned -- particularly when compared in several decimal places -- they are helpful when combined with an understanding of the actual events in the countries. Following is an overview.

The United States and Sweden had the first modern -- and expensive -- hospital systems. During the 1950's, they built many new hospitals, installed much new equipment, relied more on wage workers and less on unpaid labor (such as religious sisters and student nurses). Europe then used old buildings with multi-bedded wards; its nursing and domestic staffs were smaller, worked longer hours, received little pay. During the 1960's and 1970's, European health administrators and sick

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\*Not many are able even to understand the weaknesses in their data and methods, much less to limit their assertions accordingly. Having gone along with fallible research and advice during 1981, OMB Director David Stockman finally admitted that "none of us really understands what's going on with all these numbers. You've got so many different budgets out and so many different baselines and such complexity now in the interactive parts of the budget, between policy action and the economic environment and all the internal mysteries of the budget, and there are a lot of them. People are getting from A to B and it's not clear how they're getting there. It's not clear how we got there."<sup>14</sup>

Table II-6  
Total Health Care Spending by Service

| Country:   | <u>Sweden</u> | <u>West Germany</u> | <u>United States</u> | <u>Switzerland</u> | <u>Netherlands</u> | <u>Canada</u> | <u>France</u> | <u>United Kingdom</u> |
|--|---------------|---------------------|----------------------|--------------------|--------------------|---------------|---------------|-----------------------|
| Year:  | 1975          | 1975                | FY 1974-1975         | 1975               | 1974               | 1975          | 1975          | FY 1974-1975          |
| Hospitals  | 71.5%         | 35.0%               | 50.4%                | 44.9%              | 52.6%              | 59.0%         | 38.0%         | 62.8%                 |
| Primary and specialist care                      | 24.6          | 30.2                | { } 40.0             | { } 41.0           | 41.9               | 27.6          | 44.5          | 21.3                  |
| Self-medication                                  | 3.5           | 4.5                 | { } 5.0              | { } 5.0            | ?                  | 4.5           | 3.8           | 3.2                   |
| Other (public health, research, education, etc.) | 0.4           | 24.3                | 4.9                  | 9.1                | 1.1                | 7.2           | 4.4           | 11.8                  |
| Administration                                   | 0.4           | 6.0                 | 4.7                  | ?                  | 4.4                | 1.7           | 9.3           | 0.9                   |
| Total  | 100.0%        | 100.0%              | 100.0%               | 100.0%             | 100.0%             | 100.0%        | 100.0%        | 100.0%                |

Source: Maxwell, Health and Wealth (op. cit.), p. 83.

funds intentionally caught up with the United States and Sweden by modernizing or completely replacing hospital buildings, installing modern equipment and comforts, and adding many technicians to the wage bill. The nursing and domestic staffs became much more expensive in Europe: recruitment into religious nursing orders diminished, all employees got the same hours and wages as other non-health workers, and the new hospital workers unions got salaries to compensate the nursing students for their work. Medical education was expanded, clinical experience in hospitals was required of all doctors, and the unions obtained normal salaries for the junior doctors. In order to catch up with the United States, nearly every country during the 1960's and 1970's had a higher annual increase in health and hospital spending than did the United States.

The United States continued to grow in spending from its high base during the 1960's and 1970's. Numbers of hospital employees continued to rise. America's costs might have increased very substantially, but for the fact that it reduced numbers of beds, even before the downturns began abroad. Other countries followed the American precedent of shorter stays in a smaller acute bed supply, greater service intensity, and a steadily increasing cost per patient-day.

Some policy-makers recently have been unpleasantly surprised that health care costs in general and hospital costs in particular have been rising faster than CPI and have been increasing in their share of GNP. But this has been true of every country nearly every year since each began its time series about health care spending.<sup>15</sup> During the nineteenth and earlier centuries, hospitals were simple, doctors earned low incomes, and daily costs were low.<sup>16</sup> As the staffing and technology of hospitals modernized, hospital costs were bound to go up faster than other indicators in the economy.

But countries rise to a different degree. Britain's health care costs consistently increase more slowly than other countries'. Canada in recent years has increased no more than the general price level, a unique pattern. While the United States rises more than prices generally, this is not true every year. Increases were about equal to or less than the general price rise during periods of general

wage and price controls, such as World War II and the Economic Stabilization Program of the Nixon Administration.

The clinical problems facing hospitals in all developed countries changed while the Europeans were trying to modernize along the early American lines. Acute and extended care became distinct. While some acute care continued to be the restoration of the temporarily ill and injured to health, new technology and treatment made possible the prolongation of life in varying levels of discomfort. Since it seemed possible to save patients who earlier were doomed, many acute hospitals became busy and expensive centers for technology and expert staffing. To control costs and free beds, efforts were made in all countries to shorten stays and (recently) to perform the simpler tests and treatments in outpatient services. The cost-control efforts came from sick funds and governments; freeing beds for interesting new clinical challenges was often proposed from within the hospitals and medical staffs.

More numerous than ever were the infirm elderly who required non-acute care. Less advanced technically, the non-teaching European general hospital had long housed them on wards with acute cases. The European countries with the more ambitious building programs (such as France and The Netherlands) were able to create a division of function among acute, intermediate, and extended care, either in separate buildings or in separate services in the same building complex. Because of the aging of their populations and the ability of modern medicine to keep people alive, many of the acute patients are elderly.

In the Anglo-Saxon countries (Britain, the United States, and Canada), private enterprise created nursing homes for the elderly, thereby freeing beds in acute hospitals. A persistent management problem has been their coordination with the acute hospitals. Problems exist in financing -- adequacy of provision for the patient and honesty in institutional provision -- since the financing system in these countries (health insurance in the United States and Treasury payments in Britain and Canada) are oriented toward acute care.

In contrast to the countries that developed extended care hospitals and nursing homes with varying success, a few countries have not yet altered their tradition of mixing the infirm elderly into the

acute services. An example is Germany. Several statistical aberrations result. Length of stay and total patient-days in acute hospitals appear longer in Germany than elsewhere. The daily charge is averaged over budgets and patient-days that include extended-care as well as acute patients, and it seems lower than that of many other countries, even though total costs of the system are high.

One might think that level of expenditure is related to type of social and health system. Several researchers have noticed that the richer the country, the higher the proportion of GNP spent on health care.<sup>17</sup> But, among developed countries, not even this pattern is true, and countries with dissimilar organizations have comparable levels of spending. For example, the biggest spenders are the citadel of medical capitalism (the United States), a decentralized government health service (Sweden), and two systems of national health insurance involving much bilateral bargaining (Germany and Holland). Among the lower spenders are a national health service (Great Britain) and three forms of national health insurance (Belgium, Japan, and Italy until recently). Levels of health spending depend on social priorities, political will, and the leverage of payers over providers. How these forces operate is the purpose of this monograph.

#### NEED, DEMAND, AND VOLUME OF SERVICES

The most important macrostatistical analysis should be relating the need for hospital and health services with levels of spending and provision. The sicker populations should spend and build more; the facilities should fit the morbidity pattern. A few writers have collected and compared information from many countries indicating levels of health, spending, and facilities.<sup>18</sup>

But this approach founders, because countries lack accurate macrostatistics about the incidence of diseases and injuries. Instead, they collect and report national statistics about the causes of death.<sup>19</sup> Even these have defects: the information is not collected in identical ways, definitions are not standardized, multiple conditions associated with terminal illness in particular are not counted alike.<sup>20</sup> The

shortage of morbidity data within even developed countries seriously handicaps health planners, since their central problems are to define when an area is sufficiently provided with beds and to estimate the expansion and subsidization needed somewhere else. Lacking morbidity information for the entire country, the planners in the British Department of Health and Social Security have had to use mortality rates as a substitute, with constant worries about poor correlation with morbidity.<sup>21</sup> Utilization rates measure the work of the existing facilities, not the needs -- whether met or unmet -- of the population.

Efforts to improve comparative data collection are recent but eventually will permit relating need and service levels. Census bureaus throughout the world are working on the improvement and standardization of epidemiological information, both multilaterally and through WHO. General pilot studies have been done about the utilization of hospitals, in order to standardize methods of reporting.<sup>22</sup> One study related utilization to the different age and sex profiles of the populations, a first step in estimating clinical needs.<sup>23</sup>

Since the national data about morbidity are not yet sufficient in number and reliability to explain the determinants of hospital provision, they are also insufficient to describe the effects unambiguously.<sup>24</sup>

While it is not yet possible to correlate hospital provision with clinical characteristics of the larger society, one can relate features within the hospital sector itself. For example, when countries are compared, the strongest correlate of rate of utilization is the country's supply of beds,<sup>25</sup> a relationship often noticed in studies of regions within a country.

## FOOTNOTES

1. As in the attempted typologies in Robert F. Bridgman and Milton I. Roemer, Hospital Legislation and Hospital Systems (Geneva: World Health Organization, 1973).

2. Henri Anrys et al., Les hôpitaux dans le Marché Commun (Bruxelles: Maison Larcier, 1977); and the comparative manual of terminology by the Hospital Committee of the European Economic Community, Hospitals in the EEC (Lochem: Uitgeversmaatschappij de Tijdstroom, 1978).

3. For example, Paul Quaethoven, Het statuut van de ziekenhuisgeneesheer in de lid-staten van de Europese Economische Gemeenschap (Leuven: Monografie van de School voor Maatschappelijke Gezondheidszorg, Katholieke Universiteit Leuven, 1969).

4. The United States is often unable to fill out the standard questionnaire in international surveys attempting to compare the dominant institutional arrangement in each country. For example, Bridgman, op. cit., (footnote 1, *supra*).

5. Robert J. Maxwell, Health and Wealth (Lexington, Mass.: Lexington Books, 1981), p. 23.

6. Egon Jonsson and Duncan Neuhauser, "Hospital Staffing Ratios in the United States and Sweden," Inquiry, Volume II, Number 2, Supplement (June 1975), pp. 128-137.

7. Differences in hospital organization and in staffing were even wider earlier in the twentieth century. Comparative data during the 1950's are reported in Milton I. Roemer, "General Hospitals in Europe," in J. K. Owen (editor), Modern Concepts of Hospital Administration (Philadelphia: W. B. Saunders, 1961), pp. 29-30. Described after my first field research in European hospitals during the early 1960's in Glaser, "American and Foreign Hospitals," in Eliot Freidson (editor), The Hospital in Modern Society (New York: The Free Press of Glencoe, 1963), pp. 37-72.

8. For example, Joseph G. Simanis and John R. Coleman, "Health Care Expenditures in Nine Industrialized Countries, 1960-76,"

Social Security Bulletin, Volume 43, Number 1 (January 1980), pp. 3-8; Jean-Pierre Poullier, Public Expenditure on Health (Paris: OECD, 1977); and William Glaser, The Doctor under National Health Insurance (New York: Bureau of Applied Social Research, Columbia University, 1977; distributed by the National Technical Information Service), esp. pp. XI-24 through XI-26.

9. Howard M. Leichter, A Comparative Approach to Policy Analysis: Health Care Policy in Four Nations (New York: Cambridge University Press, 1979), pp. 95-99; and Joseph P. Newhouse, "Medical-Care Expenditure: A Cross-National Survey," The Journal of Human Resources, Volume 12, Number 1 (Winter 1977), pp. 115-125.

10. CERC (by Norbert Paquel et al.), Le cout de l'hospitalisation: Comparisons internationales (Paris: Documents du Centre d'Etude des Revenus et des Couts, Number 48, 1979). The French volume is the most extensive comparison of organizational and financial statistics about developed countries' health services in general and hospitals in particular.

11. A comparison of the reliability of methods for collecting American utilization data is James Lubitz, "Different Data Systems, Different Conclusions? Comparing Hospital Use Data for the Aged from Four Data Systems," Health Care Financing Review, Volume 2, Number 4 (Spring 1981), pp. 41-60. Any cross-national comparisons of utilization must be corrected for subtle variations in recording, such as those discovered in Lola Jean Kozak et al., "The Status of Hospital Discharge Data in Six Countries," Vital and Health Statistics, Series 2, Number 80 (Washington: National Center for Health Statistics, 1980).

12. Harold S. Luft, "National Health Care Expenditures: Where Do the Dollars Go?," Inquiry, Volume XIII, Number 4 (December 1976), pp. 344-363. The National Health accounts of the United States are based on collection methods that HCFA or its data suppliers occasionally correct. Therefore, each year's accounts contain revisions of entire time series back to 1965, in the light of the corrections in methodology and changes in interpretation.

13. Such a plan -- preceded by an extended discussion of the different conventions in health expenditure data among the European countries -- is in Alain Foulon, Les dépenses de santé dans les comptes nationaux du S.E.C. (Paris: CREDOC, 1979, prepared for the Statistical Office of the European Communities). The CERC report (cited in footnote 10, *supra*) repeatedly discusses whether statistical differences among countries reflect reality or are artifacts of statistical methods. At page 66 are two different estimates of proportions of GNP spent on health among OECD countries, resulting from the statistical methods of the reporting agencies.

14. William Greider, "The Education of David Stockman," The Atlantic Monthly, December 1981.

15. The United States has the oldest time series, going back to 1929. Herman M. Somers and Anne R. Somers, Doctors, Patients, and Health Insurance (Washington: The Brookings Institution, 1961), pp. 195-199, 537, and 545.

16. For example, William Glaser, Paying the Hospital in France, pp. I-16 and I-17.

17. For example, Leichter and Newhouse, cited in footnote 9, *supra*; CERC, cited in footnote 10.

18. For example, Robert Maxwell, Health Care: The Growing Dilemma (New York: McKinsey and Company, Second edition, 1975).

19. World Health Statistics Annual (Geneva: World Health Organization, Annual), Volumes I and II; and Health Services in Europe (Copenhagen: Regional Office for Europe, World Health Organization, 1975).

20. A. J. Culyer, Need and the National Health Service (London: Martin Robertson, 1976), Ch. 10.

21. Britain's RAWP methods are described in Glaser, Paying the Hospital in England, Ch. V.

22. Robert Kohn and Kerr L. White (editor), Health Care: An International Study (London: Oxford University, 1976); and Robert Bridgman, Hospital Utilization: An International Study (London: Oxford University Press, 1979).

23. Bridgman, Hospital Utilization (op. cit., footnote 22, supra).
24. As in the attempts to estimate the effects of personal health expenditures on infant mortality, in R. D. Fraser, "An International Study of Health and General Systems of Financing Health Care," International Journal of Health Services, Volume 3, Number 3 (1973), pp. 369-397.
25. Kohn, Health Care (op. cit., footnote 22, supra), Ch. 8.

## CHAPTER III

### HOSPITAL FINANCE AND THIRD-PARTY PAYMENT

Every organization's current characteristics are somewhat unique, because of its origins and evolution. Many organizations can be treated alike because they indeed operate alike and have done so for a long time. Much of the research and policy advice about American hospitals today attempts to apply hypotheses and prescriptions derived from other organizations, particularly the "economics of the firm." A question is whether hospitals fit, or whether they behave -- or should behave -- very differently. Understanding that requires perspective about what hospitals have been like until now.

This chapter will summarize the economic history of hospitals and the history of third-party payment for inpatient care. The presentation has several purposes. Hospitals have many peculiarities in all countries today because their economic history has differed from the evolution of business firms. Hospitals in America and Europe share similarities and differences, and their history is essential to illuminate the contrasts. At certain crucial points, Europe and the Anglo-Saxon countries moved in different directions; at other points, the United States, Britain, and Canada diverged among themselves. The narrative will explain why other countries and the United States handle some matters differently and is essential to estimate the feasibility of incorporating certain foreign methods into the American setting.

#### HISTORY OF HOSPITAL FINANCE

Hospitals for centuries in Europe and in the Anglo-Saxon countries were charitable works of churches and of voluntary associations. They did not have budgets and price schedules.<sup>1</sup> They depended heavily on donations for buildings, equipment, and supplies. Many employees were volunteers -- religious orders assigned nuns and monks, many

physicians at first donated their time -- and many were indigents who worked in return for food and housing. Two-thirds of the budgets of hospitals today are spent on wages, and they require a considerable revenue; but, until the late nineteenth century, at least half of hospital budgets went for food, and little cash was needed for wages.<sup>2</sup>

In recent centuries European and North American hospitals became more involved in society's markets for buying merchandise, food, and labor. For a long time, these purchases merely supplemented the donations of goods and labor. The money used for purchases itself was based on donations: some hospitals or their owners had endowments (land, vineyards, investments) yielding a steady income; much new money for investment and operating costs was donated every year; local and national governments provided grants. Hospital managers, governing boards, and parent associations devoted much effort to ceaseless fund-raising and soliciting donations in kind.

As the nineteenth century progressed, donations of buildings, equipment, supplies and labor went out of fashion. Toward the end of the century, fewer employees lived in the hospital, fewer donated their labor, more wanted wages. The hospitals' cash needs in every country increased, putting greater pressure on the hospitals' managers and owners. Patients had often been charged small amounts for things the hospitals had to buy for them, such as food, bandages, and medicines. Gradually during the nineteenth century, patients were charged more.

The cash economy that had long governed Western urban life steadily infiltrated the hospitals. The managers had to anticipate the expenditures they must make during a forthcoming period (such as a year) for their anticipated work, and then had to find the money as early as possible. The charges from patients were necessitated by the fact that donations were not keeping up with costs, but the charges were not equal to the whole budget. Not until well into the twentieth century did nonprofit hospitals in Europe and North America balance their budgets entirely from patient charges.

A nonprofit hospital had a mission and searched for the money to cover its costs. Meanwhile, almost everyone else in society had a different style of economic behavior. They wanted to become rich or,

at least, comfortable. Businessmen -- individuals and groups organized in companies -- had greater discretion and mastery over means than ordinary workers. The businessmen selected a line of work, amassed the means, looked for customers, produced and sold goods and services. They had to cover their costs from earnings and could not plead for donations; but they were expected to earn cash surpluses over costs, to elevate their personal living standards and to buy more inputs for their firms. Compared to a hospital, a business firm was not expected to break even or stand still. It could earn large profits, grow, and perhaps add new products and services. If it ran losses, it would change in one of several ways: seek new customers in a desperate short-term effort; reduce its inputs, scale, and costs; convert its outputs to a different market; or go out of business.

After the Renaissance (when doctors were still monks), health services in all Western countries developed paradoxically. A hospital was a charity; it sought money to cover its costs, never accumulated profits, and rarely went bankrupt. A doctor was a businessman who sold services to customers, earned as much as he could, and used his profits to raise his personal living standards and to improve his practice. A doctor could go bankrupt and could change to another career.

Until the late nineteenth century, the average doctor saw his seriously ill private patient in the latter's home. Treatments and births were at home. When new improvements in asepsis made more advanced surgery possible, doctors created cleaner and more efficient arrangements ("private clinics") in buildings connected with their offices. Often the doctor lived there. Paying patients preferred living there for several days instead of going to nonprofit and public hospitals, which had large wards, full of the poor. The doctor's "private clinic" was part of his business, an extension of his office practice. Patients were billed for their costs as well as for his fee, and he tried to make profits on both services.

Private clinics became common throughout Europe and North America during the late nineteenth and twentieth centuries. They outnumbered the nonprofit and public hospitals in every country, but each was small, since each was a workplace for an individual doctor.

For example, the United States in 1910 had 2,441 private clinics and 1,918 hospitals.<sup>3</sup>

Hospitals in Europe were gradually able to cover their costs from charges to patients. The method was the all-inclusive daily charge, calculated almost everywhere in the same way. The director estimated his total costs for the coming year. He estimated the expected total patient-days. Expected total budget divided by expected patient-days produced a daily charge, billed to all patients during the next year. A neutral regulator, such as the prefect in France, might review the calculations to confirm that the prospective budget was justified and the expected number of patient-days reasonable. The calculations were designed to break even: the hospitals were assured neither more nor less than their costs. Covering all costs through charging patients was feasible, because national health insurance gradually spread to more people; the hospitals billed the patients' sick funds and were guaranteed full payment.

The private clinics for many years were not covered by this payment method. They were not established to serve society in a charitable fashion -- except in the English language, they were never called "hospitals" but were always called "clinics" -- but they were business facilities of their doctor-owners. The nonprofit prepayment system for ambulatory and inpatient care was not supposed to guarantee the operating costs of an enterprise whose owners charged customers with a margin of profit. Operating a private clinic was a normal business risk of specialist physicians. Until the 1940's, clienteles and payment were separated in Europe: the lower classes were covered by sick funds committed to payment in full and went to the nonprofit voluntary and public hospitals; the upper classes paid cash or were covered by commercial insurance policies paying indemnities, and they went to physicians and private clinics that set their own charges.

In every country of Europe and North America after 1930, the private clinics declined steadily in number and importance, as patients accepted hospitalization in improved nonprofit hospitals and as their medical staffs acquired rights of private inpatient practice. Office doctors could collect charges high enough to cover their own practice

costs along with an honorarium, but (with some exceptions) not enough to cover the mounting costs of private clinics.

European sick funds guaranteed payment of the medical costs of subscribers and became adequate to guarantee the costs of hospitals, because of the way of calculating hospital charges. The sick funds' coverage was sufficient, when the laws expanded membership and required contributions from employers. Originally designed to cover the bills by doctors for ambulatory and home care, the sick funds by ingenuity had become prepayment mechanisms that guaranteed financing of the hospitals. The method had the additional virtues of simplicity and administrative economy: all patients were pooled in the calculation of the total budgets and patient-days; within each hospital, every patient was charged the same daily rate. As the hospitals costs rose, the system guaranteed a steady increase of payments by sick funds and by self-paying patients. Prospective budgets increased every year, they were divided by predicted numbers of patient-days, and patients (or their sick funds) were charged a higher daily rate every year. Monitoring by public regulators or by the sick funds' negotiators restrained annual increases in costs. Once the sick funds' obligations were known, the subscribers and their employers were expected to pay the required premiums.

The Anglo-Saxon countries did not evolve in this way. Insurance was a method for providing cash for patients when they became ill, to make up loss of income and to pay for the only bills they received, viz., the charges of doctors. Some British sick funds (the "Friendly Societies") during the late nineteenth century became prepayment mechanisms for doctors: the revenue was passed on to doctors at once in capitation fees, and the doctors gave all care to the members without additional charges. Hospitals were separate from these arrangements; their managers, boards, and owners found the money themselves, and insurance did not pay for inpatient stays. Many hospitals created "contributory schemes" like the Friendly Societies' contracts with doctors: a person paid a weekly subscription charge to a hospital, the hospital received the revenue at once for current operations, and the subscriber was hospitalized with no or few charges whenever he needed to be.

Long after Europe had developed a method of guaranteed cost reimbursement for its nonprofit and public hospitals -- standardized throughout each country and yielding additional money every year -- every hospital in Great Britain, Canada, and the United States continued to find its own money by a variety of methods. A few organized contributory schemes like Britain's. Americans seemed to prefer indemnity insurance with a freer choice of hospital, since they depended on the clinical and referral decisions of their general practitioners. Individual hospitals and groups of hospitals during the early 1930's fostered prepaid insurance arrangements, whereby an office collected premiums from subscribers and their employers in varying proportions; the agency invested the revenue in its own fund instead of distributing it to the hospitals at once; and the office negotiated a charge schedule with participating hospitals. These "Blue Cross Plans" were joined by several contributory schemes, who converted to the prepaid insurance method. A goal was payment in full, with few out-of-pocket by patients, but the actual arrangements varied across the country; the Plan representatives could review the hospitals' predicted costs before setting the premiums for the coming year. Blue Cross prepaid only some of each hospital's costs, since only some patients belonged. Some other patients could be charged, with rates often varying by their apparent ability to pay. Donations were solicited from the public. Blue Cross did not have many subscribers in the Western provinces of Canada, and the provincial governments created tax-supported funds to pay for their citizens' hospital care.

British voluntary and local authority hospitals were impoverished at the end of World War II; the prewar method of constant searching for money in many places was laborious and inadequate. Blue Cross and the mixture of other methods left Canadian hospitals strained. So, two countries with a long tradition of individualism and self-help went to the opposite extreme of full government financing of all hospital budgets and of all investments. In Britain, the national government took over ownership and financing. In Canada, ownership remained with voluntary associations, but every hospital's annual budget was paid for

in full by provincial tax revenue, aided for many years by large grants from the national government.

The United States has continued to struggle with the mixed financing of hospitals. Blue Cross expanded in membership, retained its commitment to pay all costs for caring for its members, and obtained steadily more revenue from employers' contributions. Government helped pay for two important user groups, viz., the elderly (paid by supplements to national social security taxes) and the poor (paid by general revenue from state and national governments). Like Blue Cross, Medicare and Medicaid were supposed to cover hospitals' costs for those patients. But since coverage by those methods is not universal, American hospitals cannot be assured of full financing -- no more and no less -- by the simple methods of European health insurance. Each hospital has unexpected bad debts; each continues to raise money through its own sliding scales of patient charge, donations, and special fund-raising. Each hospital has risks and opportunities, and its outcome each year cannot be predicted exactly. Each year some run deficits, and others surpluses. In the absence of an agreed method of screening performance and awarding rates, controversy grew during the 1970's over whether hospitals were wasteful or were being underfunded.

The smaller and less equipped private clinics have declined abroad, disappearing completely in some countries. All were excluded from Treasury grants in Canada and Britain; all in Canada and nearly all in Britain were dissolved. Private doctors and political conservatives were influential enough in several European countries (particularly France, Germany, and Belgium) that the law entitled the insured person to choose his doctor's personal clinic. A few large and well-equipped clinics became a new form of "private hospital" like the American proprietary, eligible to collect full sick fund rates. They had prospective budget review and regulated or negotiated all-inclusive daily charges, much like the nonprofit hospitals. Profits were not allowable costs and therefore the establishments became nearly like nonprofits themselves; the doctor-owners gained through institutional salaries and clinical fees. In several countries (such as Germany),

the private clinics admitted to sick fund practice were integrated into governmental hospital plans.

The last country with the old methods of mixed financing, the United States, treated its private clinics differently from the other countries. The payment system was not standardized in a nonprofit mode. In a country where the economy had remained in private hands and where private initiatives were considered the engines of the public good, the private clinics were accorded the usual financing status with carriers and with government. Even profits became allowable costs under cost reimbursement methods. When payment-in-full was guaranteed for the aged and poor, private clinics revived in number. New and well-equipped establishments were created by business corporations managed by laymen and capitalized with publicly traded stock.

#### THIRD-PARTY PAYMENT: DEVELOPMENT OF DIFFERENT NATIONAL STYLES

Traditional insurance concepts. Insurance is a method of saving money to pay damages, if an adverse event occurs. The prospective victim pays premiums into a fund. The accumulated premiums plus the earnings of the fund cover the reimbursement guaranteed in case the adverse event occurs. Risks are spread: all premiums of many subscribers are pooled, and the large fund is sufficient to cover victims of the specified damages.

Originally in both the United States and Europe, insurance policies were written individually. The industry developed tables about the probability of the adverse event (such as death, a fire, or loss of a ship) for a person with certain characteristics. The underwriter for the company compared the applicant with the tables, picked the premium rate that would (when accumulated with time and earnings in the company's reserves) cover the future risks. The underwriter normally includes a margin of safety in the premiums. In theory, a company could accept all risks and charge high premiums for the worst. In practice, each company developed distinctive pricing and underwriting methods, specialized in particular ranges of customers, and avoided adverse risks.

Insurance became highly competitive in both North America and Europe. Companies relied on agents to find customers and draft proposals that the underwriters in headquarters converted into policies. The agents earned commissions calculated as a percentage of premiums. Therefore agents had the incentive to sign up as many customers as possible, with each buying the most expensive cover.

Traditional insurance principles have been: individual policies tend to follow actuarial norms and certain practices of a company; insurance for substantial risks that occur rarely; payment of a particular sum when damage occurs; the sum is related to the person's prior contributions; persons who are exceptionally adverse risks are either charged expensively or are rejected; false claims ("moral hazard") are avoided by very precise definition of the adverse event and by investigations. Some insurance began to be designed for groups, wherein all members subscribed, were charged the same premiums, and received the same protection. The actuarial calculations for individuals of certain types were averaged for each group: underwriters tried to estimate the probably risks for the average group members; later the underwriters could estimate retrospectively from the experiences of such groups (i.e., "experience rating" as the basis of premiums).

Some companies and special societies began offering health insurance policies (at first called "casualty insurance") during the nineteenth century. At first, the problem was defined and insured like life insurance: an accident or serious illness unexpectedly occurred to a previously healthy person.

"Health insurance" has always been a hybrid, inspired by different actors with varying motives and methods, following some traditional insurance principles and violating others. The key actors in every country have been the workers, employers, insurance companies (mutual or commercial), nonprofit carriers and societies, and the health providers. Their interaction has varied among countries, producing different outcomes in the United States, Britain, and Europe. Health insurance has been shaped in particular by the early decisions about how to provide compensation and treatment for workers experiencing accidents at work.

The different traditions in health insurance. Two rival positions have been social solidarity (whether egalitarian or hierarchical-paternalistic) and individualistic liberalism. Social solidarity in some form has won out in Europe while self-help liberalism has controlled health insurance and social security generally in the Anglo-Saxon countries.<sup>4</sup>

1. Before general legislation:

(a) Sickness. Workers in many European countries long before 1900 had developed mutual aid societies to pay for funeral costs, widows' benefits, disability benefits when the workers could not work, and costs of care. Benefits were low and uneven. Work injury and non-work-related illness of the worker were covered. A few European employers contributed cash and administrative assistance; others thought this was not their affair, and workers contributed alone. Some European funds paid for hospital care. Physicians were as concerned as the workers to improve the finances of the funds. Commercial insurance companies were not involved.

Britain already showed the signs of a different approach from Europe in two regulatory laws during the nineteenth century. It applied to the funds ("Friendly Societies") the same regulations as it had to commercial insurers in other fields. Instead of finding new money and expanding benefits, the laws required the funds to keep premiums and benefits actuarially in balance, even if benefits must be cut. Benefits were predictable cash sums, usually not services. The British funds competed for new business and had high costs of sales and collection, like any insurance company.

(b) Work injury. National policy in Britain and in North America was individualistic, as enunciated by common law courts. Employers were nearly exempt from liability in practice. They were obligated to pay a worker only if the latter proved in court that the employer was negligent and that the worker committed no contributory negligence. Even so, the employer

was not liable if the worker could be shown to have assumed the risks of the job.

No European country adopted such a sweeping policy, in legislation or in judicial practice. Doctrines like assumption of risk and contributory negligence did not exist. Employers were supposed to maintain safe workplaces and were supposed to be considerate of their workers. Liability in Europe was ambiguous and enforcement depended on law suits by the victims. Employers might be expected to pay for medical care as well as short-term and long-term disability benefits.

2. Workmen's compensation laws:

- (a) Britain and North America. Assumption-of-risk and contributory negligence by workers were extreme and untenable exemptions of employers' liability. Too many workers and their families were being ruined. Employers had no incentives to maintain safe premises and to avoid child labor. The Anglo-Saxon countries amended their laws around 1900 to redefine risk as one borne by the employers.

His liability was to pay compensation to the worker, a proportion of the latter's wage, varying by type of injury and length of incapacity. Since the problem was to cover actuarially predictable rates of risk in each industry and occupation, and then to compensate with finite sums of money, Britain's flourishing commercial insurance industry soon took over the field by offering policies to businessmen to cover the risks. Policies insured the employer against liability; they did not insure the worker against injury. Premiums were a business cost for employers. The insurance companies included in their costs considerable overheads, including sales and the costs of litigating against the workers' claims. Benefits were low and fixed cash payments, as in the companies' policies for life and property loss; benefits were not guarantees of all necessary treatment. The debate over workmen's compensation in Britain and in North America did not involve

other health insurance, since employers were liable to pay only cash compensation, not medical care.

- (b) Europe. The debates in each European country linked work-related injury and non-work-related sickness as equally serious disasters, even if legislation for the two were not enacted simultaneously. Individualistic business interests were not as powerful in most of Europe as in the Anglo-Saxon countries; they could not delay legislation so long or keep the benefits so low. Workmen's compensation laws were on the books in Prussia as early as 1838. Usually the costs were to be borne by employers; many laws created special funds or used existing sick funds, with employers paying a premium per employee in advance, sometimes supplemented by smaller premiums by the workers. Administering benefits through sick funds enabled employers to satisfy any obligations to contribute to the victims' medical care.

3. Health insurance laws:

- (a) Europe. The sick funds needed more members and money to pay for care. Otherwise, death benefits, disability benefits, and widows' pensions would use up the money, leaving little for the doctors and very little for hospitals. Providers and unions alike sought better health insurance coverage at the time of the debates over workmen's compensation.

The improvements were linked. Several European governments consciously enacted both laws plus old-age pensions as a package, uniting employers and employees, with financial contributions from both. All workers in an industry were covered. All employers were expected to contribute. While special machinery was needed to review workers' claims under workmen's compensation laws, the premiums and benefits in several countries were administered by their sick funds.

- (b) Anglo-Saxon countries. On principle, their business classes and governments presumed that paying for health care (beyond workmen's compensation) was the responsibility of the individual. People helped themselves and exercised foresight.

Paying the doctor was a private transaction. Britain had nonprofit societies operating much like insurance companies; they tried to experience-rate their subscribers, fixing premiums and cash indemnities to defray the costs of visits to doctors. Enough doctors were impoverished in private office practice to accept closed-panel capitation agreements with some Friendly Societies. Competition kept premiums, indemnities, and fees low.

A national controversy over Britons' health around 1900 extended to non-work-related disability. Recruitment for the Boer War revealed the poor health of the entire population, for war as well as for work. The Liberal Government in 1911 passed a very restricted law, sold on grounds that it would improve the nation's human capital, making industry more productive. Workers were required to join Friendly Societies; their employers invested to make the prospective returns possible, by matching the workers' premiums.

The Friendly Societies still lacked the funds to pay for hospitalization. The voluntary hospitals still found their own money from charity and from prepaid "contributory schemes" for prospective patients.

Canada and the United States did not go even this far in legislation. Most of Canada relied on private health insurance until 1958. (Saskatchewan broke ranks in 1946 by adopting a provincial hospital benefits program that mixed insurance methods and general revenue methods.) The United States enacted its only compulsory health insurance in 1965, in its very limited Medicare.

#### 4. Subsequent evolution:

- (a) Europe. Each country followed a different time-table: for example, French businessmen delayed enactment and implementation of NHI laws later than elsewhere; Switzerland followed an entirely different history, like a mixture of Europe and the United States. Generally, coverage was steadily expanded, to include more workers and their entire families. All sick

funds eventually became committed to payment for services and not merely payment of cash sums to the victims. They paid providers and not beneficiaries. Mounting costs were covered by higher premiums on both workers and employers. Workmen's compensation and national health insurance were coordinated, often merely different clauses in social security codes, with benefits often administered by the same sick funds. NHI became a standardized, comprehensive method of covering every population, while the Anglo-Saxon countries tried to cover their populations by a mosaic of categorical programs.\*

In Europe, small sick funds for the workers at each factory calculated premiums according to probable costs of care (i.e., experience rating) within the limits of the workers' incomes. Larger funds arose, with members from different workplaces and neighborhoods, and members were charged average premiums for average costs (i.e., community rating). Europe has seen a steady trend for the merger of small funds and the absorption of small overstrained ones by larger ones; community ratings for regions or even for the entire country have replaced experience ratings.

- (b) Britain. The grudging National Health Insurance of 1911 yielded too little money to improve care for the population and to provide adequate facilities and income for office doctors. The Depression destroyed charity and reduced the collections of the hospital contributory schemes; the voluntary hospitals were bankrupt. The country lacked the organization and mutual-aid ideology for a system of sick funds depending on employers' contributions. The Labour Party had always argued that employers were so uncooperative and workers

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\*An exception to the orderly European evolution was Italy. Compared to other countries, it did not levy high enough payroll taxes on the workers; extensive unemployment limited the financial base of the sick funds; effective prospective payment controls were not imposed by the sick funds on the hospitals. During the 1970's the sick funds and hospitals went bankrupt, and the national government (as in Britain in 1946) bailed them out by enacting a Treasury-financed National Health Service.

were so poor that the only solutions were extensive public ownership and management of health services, Treasury financing, and compulsory social security taxation of employers. Labour happened to be in power just after World War II, did not try to redesign NHI and the Friendly Societies along European lines, and enacted the National Health Service. Health delivery seemed so parlous and private insurance (whether commercial or nonprofit) so feeble in resources that hardly anyone has dissented, either in 1946 or since.

- (c) Canada and the United States. Transplanted to North America, the British system of owning, managing, and financing health services worked badly but not catastrophically. The problems were fewer: Canada and the United States were not so industrialized and urbanized, had much less social inequality, had less misery. More persons could pay out-of-pocket. As in Britain, commercial insurers underwrote risks for employers in workmen's compensation; their customers were the employers and not the workers, and they could attract business best by minimizing payments to the workers.

At first, commercial insurers entered the sickness benefits market by covering the loss of wages during illness, a finite and predictable risk. The policies were bought by individuals or by groups of employees. Eventually the insurance companies entered the medical expense market in the manner most consistent with traditional insurance principles, by offering fixed indemnities for each illness or injury, varying by severity. The patient's treatment costs were likely to be higher, and he paid the rest out-of-pocket. Medical expense insurance by insurance companies eventually became important in the United States but was displaced by other methods in Canada. The insurance companies used their customary methods of manual rating for individual policies and experience rating for groups.

In both Canada and the United States, hospitals and doctors looked for secure methods of reimbursement and developed

prepayment schemes different from commercial insurance. The hospitals in several American states and Canadian provinces created Blue Cross Plans paying indemnities to patients or third-party service benefits to hospitals. Hospitals particularly needed to guarantee collection for the more expensive patients; but manual or experience rating for such persons might have deterred them from subscribing. Just as the North American hospital has always loaded parts of its higher bills onto the lower bills, Blue Cross at first community-rated its groups, standardizing rates regardless of individuals' past utilization and future risks. Eventually the Blues added group rating methods.

Medical societies in Canada sponsored prepaid funds, to cover the costs of doctors' fees, usually for hospital care and sometimes for office work. The medical plans paid indemnities, rarely direct benefits. Similar arrangements developed slowly in the United States.

The Canadian market was too small, the subscribers' incomes too low, and Canadian hospitals could not match the rising facilities and service levels they saw enviously in the United States. To pay for that type of care, the national and provincial governments during the 1950's replaced all commercial insurance and provider prepayment funds with direct Treasury financing for all hospitalization and physicians' care.

- (c) United States. By the 1970's, Britain and Canada had abandoned the tradition of multiple categorical private and public financing programs, but the Americans were still trying to make it work. Hospital finance had proved the Achilles Heel in Britain and Canada, forcing the adoption of full Treasury financing, since no system of sick funds had built up reserves and premium levels, since no method of rate regulation was in place. The Americans could buy time by making Blue Cross a conduit for money, with less resistance at either the collection or reimbursement ends than the European sick funds or

private American commercial insurers showed. European sick funds drove bargains with hospitals or paid rates set by regulators; American stock companies offering health insurance paid only predictable indemnities, in keeping with insurance practice. Some European sick funds had their premiums fixed by Parliament or by stingy regulators; others simply hesitated to charge too much. American Blue Cross had many individual policies with contributions from both workers and employers; for a long time, state insurance commissioners raised Blue Cross rates generously, since their mandate in all their insurance duties was to make sure that revenue was sufficient to cover costs. For many years, commercial carriers (both mutual and stock-company) and Blue Cross competed to offer higher benefits rather than lower premiums. Much money was pumped into the system by fringe benefits: labor contracts committed employers to allocate a large sum and then to ask Blue Cross or a private carrier to write a benefit package. The United States and state governments paid Blue-Cross type benefits for the aged and for the very poor.

The current mixture of prepayment and insurance. By 1981, all countries had developed systems differing from straightforward insurance principles.

1. Instead of a simple risk easily priced, health financing had become preoccupied with the coverage of services. Providers and patients wanted full coverage; patients wanted coverage without cost-sharing. Where sick funds, nonprofit funds, and for-profit insurance companies competed for new customers -- either attracting the uninsured or winning subscribers from competitors -- they offered higher benefits. Individuals and purchasers on behalf of groups in every country seemed to prefer the higher benefits, even with the higher weekly or monthly premiums. Other insurance is rarely written for the purchase of services.

Therefore, much of what is called "health insurance" really is a form of group prepayment for services. Some prepayment arrangements were tied to particular providers, such as British hospital

contributory schemes, the insurance panels of early twentieth century British and German medicine, the health centers of present-day French mutuelles, and American HMO's. These arrangements differ from insurance in that they cannot fix an indemnity based on an accurate actuarial prediction of the cost of covering a risk. The insurer and his provider are at risk, motivating them to overcharge (which is difficult) and/or underserve.

The United States is the only country that still uses "insurance" extensively in its health insurance. Many policies guarantee only indemnities, not third-party service benefits. As a result, America's premiums are low by world standards.

2. An insured risk normally is large and rare. But most health insurance expenditures pay for small and frequent events. Catastrophic bills comparable to the problems covered by life and casualty insurance are rare. Unique to America, the specialized catastrophic policies usually are no longer limited to indemnities but are committed to third-party service benefits since these are the situations giving patients the greatest payment difficulties. European prepayment systems occasionally stop at catastrophic coverage; special government programs exist in most countries to rescue the sick funds from exceptional bills and from chronic care.

Insurance usually avoids covering very small losses, since their total can be large and since they burden the carriers with much administration. Countries that cover every episode have various methods to reduce the administrative burden: Holland and Britain use capitation for general practice; Britain and Sweden include specialists' ambulatory care in their salaries; German health insurance pays item-of-service fees for every act but requires aggregation of all in quarterly bills; France bundles many details into global acts. The solution in many American Blue Shield Plans is not to cover the smaller physician services.

3. Insurance is designed for events that nobody wants. It compensates a victim. If arson, suicide, sabotage, and other acts of "moral hazard" are discovered, payment is denied. However, moral hazards are always potentially present in health insurance, where two

persons can gain by inflating claims at the expense of the carrier, viz., the patient (who gets disability benefits, drugs, etc.) and the provider (who earns his income from claims). Insurers in health therefore must install special machinery to monitor all claims; they encounter barriers and disputes in trying to investigate the work of providers, who protest they are not parties to the policies. Traditional insurance has a chronic dilemma over penalizing "morale hazards" -- i.e., claims arising more often than statistical probability because of the policy-holders' negligence -- and this arises often in health coverage, since much illness and injury are due to preventable life style.

4. Insurance is paid from a fund: policy-holders' benefits are predictable indemnities, covered by their premiums and by the earnings accumulated by the fund. However, health services constantly become more expensive, and even the traditional health insurance policies paying fixed indemnities are under steady pressure to pay out more. Most health insurers compete by offering payment for all services; services increase in number and cost for each condition historically, and each policy-holder demands more as he ages. The average policy-holder's accumulated premiums are insufficient to pay for his care, and therefore health prepayment is pay-as-you-go rather than traditional insurance. The policy-holder does not pay for himself but joins a group that pays for him: this year's collections pay for this year's medical costs, with only a small continuing reserve to cover deficits. Traditional insurance companies can maintain large reserves on their health accounts only by selling excessive coverage, by charging high experience-rated or individualized premiums (if the regulators allow them), and/or by paying fixed indemnities for a limited number of conditions.

All social security is pay-as-you-go, like the bulk of modern health prepayment. All guarantee benefits at current prices. All other social security programs are paid for by payroll taxes and are administered by government funds. The Treasury must solve the now common deficits. National health insurance is usually administered by autonomous nonprofit sick funds, and the responsibility for financial solutions is not clear.

## POLICY ISSUES IN AMERICAN THIRD-PARTY PAYMENT

The present American system. In many sectors, America has been a melting pot of ideas and institutions from different foreign cultures and from different forms of organization. In health care, many collectivist and welfare practices took root, as in European countries, viz., commitments to care for everyone, to place facilities where the entire population needed them, to cover the full costs of health care, to prepay the costs in the least painful way, and so on. The providers and not the consumers or the taxpayers were in charge of the organization and financing of health care. Blue Cross and Blue Shield dominated the private market; several insurance companies offered comparable prepaid extensive-coverage policies; and several government health programs (Medicare, CHAMPUS, FEHBP, and even Medicaid in some states) were copies of the Blues. Since the liberal and free-market elements in American tradition hinder the construction of large-scale countervailing power as a general pattern, taxpayers, prepayment subscribers, and patients did not organize collective bargaining or regulation over the providers' financial claims as early as they did in other countries.

By the 1970's, several reforms were installed to protect pre-payment and cost reimbursement. Several state governments adopted rate regulation over hospitals, to draw the line between necessary and excessive spending. The national and many state governments tried to regulate new construction and the installation of new equipment. Several state Blue Cross Plans began to bargain adversarially with hospitals. Government agencies invoked the antitrust laws to make Blue Shield Plans more independent of medical societies. The Carter Administration tried to impose a ceiling on the annual revenue of each hospital. These methods of cost containment are already in place abroad; current debates there concern how to improve them, not replace them with methods of traditional liberalism.

"Market-oriented" proposals in the light of foreign experience. The traditions of self-help liberalism survive in America -- individual ownership of voluntary and for-profit hospitals, a substantial amount

of commercial medical-expense insurance paying indemnities, out-of-pocket by patients, charge-based payment for many hospital services, etc. -- and some critics of present trends in prepayment and cost reimbursement recommend constructing the entire system of health delivery and health finance along these lines. The medical economists who dominate health services research in the United States at present search for an ideal competitive and free-market blueprint.<sup>5</sup> Several reorganizations of health finance have been proposed in Congress -- such as bills by Gephardt-Stockman and Durenberger -- that would replace prepayment for cost-reimbursement by forms of traditional insurance. The Reagan Administration favors scrapping health planning, calls for eliminating regulation of pricing and delivery in health, tries to reduce government spending for patient care, and gropes for ways to "loose the forces of the market to make the health care system more competitive."<sup>6</sup>

Following are my reflections on the feasibility of these proposals and their underlying assumptions, in the light of financing trends in the United States and other countries, in insurance generally as well as in health in particular.

Overinsurance. A common criticism of the present system of health prepayment and health insurance in the United States is that the American people are "overinsured," that they get more insurance than they "want" or "need." However, overinsurance (whatever that means) may be an inevitable outcome of a competitive system based on sales agents. In all other sectors of insurance in the United States, many companies seek business, each seeks more sales of policies with higher premiums, sales are made by agents whose commissions are proportions of premiums and whose livelihoods rise with sales, and the agents are very competitive. The system leads to overselling and duplication, and mutual companies rebate substantial dividends every year. If Americans seem to buy much health insurance, they buy much insurance of all kinds, even individual policies without "tax subsidies."\*

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\*Total life insurance coverage in the United States equals one and one-half times the country's national income, the highest in the world except for the recent surges in Japan and Canada. In every year, purchases of policies by individuals exceed in number and value purchases of group coverage by employers (e.g., in 1980, 39% more policies and 118% higher value).<sup>7</sup>

Insurance of any sort -- whether life or health -- is so abstruse to the average person that he is easily inclined to "play it safe" by picking the more complete coverage. The recent American proposals about "consumer sovereignty" presume that the individual can comparison-shop among many policies, but only someone long accustomed to the reasoning can balance the costs and benefits of different schemes designed to cover slightly different risks. Swiss insurance companies present the customer with a simple set of alternatives, but a free market in the United States could present a bewildering mixture.<sup>8</sup>

If more insurance consisted of individual policies sold by companies rather than group policies sold by the Blues -- as some devotees of free-market models seem to wish -- insurance could be more expensive in some respects and not less. Commercial insurance has a high overhead for sales. Competition increases reliance on agents, particularly the ones who can bring in the most business and who therefore demand the highest commissions. In other fields of insurance in the United States, one-quarter to half the premiums go to the agents; headquarters retains funds for sales by mail and for other costs; and up to five per cent is profit.\* In 1979, the American insurance companies used 44.5 per cent of revenue from individual policies for operating expenses. (They retained 15.0 per cent of collections from group policies, while the Blues retained 7.3 per cent).<sup>9</sup>

A common criticism is that the prepaid first-dollar coverage of all provider costs is due to the deals made by unions, employers, the Blues, and the providers. Critics predict that citizens would prefer less coverage and more personal income. However, history abroad does not bear this out. Where options are available, most (not all) persons prefer the more expensive policies with the more complete coverage. In the European country where minimum statutory requirements are lowest (Switzerland), nearly every subscriber buys from his sick fund a package of several policies that provide first-dollar coverage for all hospital services. After Switzerland, France has the most

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\*Parenthetically, one reason American HMO's appear cheap is their invisible sales effort. As a result, their market share is small. In a serious competitive market they would have to launch massive and expensive selling campaigns.

statutory cost-sharing for ambulatory care under European national health insurance, but four-fifths of the population voluntarily belongs to the societes mutuelles, which insure against all the cost-sharing.<sup>10</sup> As a result, Swiss out-of-pockets seem confined to ambulatory care, while the French have almost none. Medical expense evokes sufficient anxiety that nearly everyone is willing to pay the small increments in monthly premiums in order to be assured of more complete coverage. Tiny cash rebates for selecting cheaper and less comprehensive coverage<sup>11</sup> will be ineffective. West Germany once offered insurance subscribers rebates if they did not visit doctors, the long-run effect on utilization was minor, the costs of administering the rebates exceeded the savings in fees to doctors, and the scheme was abandoned.<sup>12</sup>

The discussions about overinsurance presume that some consumers prefer to be rational self-insurers. They would keep all their income and be ready to pay all their expenses. By leaving the pool of premium-payers, they would no longer subsidize premiums of the worse risks. However, many foreign national health insurance systems have finally made membership compulsory for those outside of occupational groups, because most non-insurers are not really rational self-insurers who maintain reserves. Rather, they are the negligent who have higher risks, lower reserves, and less regular income. Once they are sick or injured, government welfare programs are pressed to rescue them. Government must judge the benefits in each case. Many foreign governments therefore have tried to reduce their welfare administration and its controversy by letting the sick funds administer standard benefits for all.

Employers' payments and tax subsidies. A popular recent hypothesis in the United States is the inflationary effect of employers' payment of the premiums for group policies. Since the costs are a business expense, employers are said not to be motivated to seek economical health schemes, the Treasury loses revenue, and the worker mistakenly thinks his health care is "free." If the worker were paid the money in wages, he would pay taxes on it and would use the rest prudently, either to buy economical health insurance or to pay providers out of pocket. Because less money would float about and since the

worker would be conscious of prices, health care costs would be lower. The fault is allowing the employer to take a tax deduction for the group policies. Repeal that, and all the benefits follow from higher tax revenue and from true market behavior by patients.<sup>13</sup> Besides the reform of health insurance, all social security should be replaced by voluntary action the critics continue. Compulsory coverage and the employers' tax-deductible contributions breed profligacy by recipients and reduce capital accumulation in the economy. Too much money goes into social benefits and not enough into investment, with disastrous results for the economy.<sup>14</sup>

In the light of foreign experience in health insurance and prepayment, these proposals and predictions are unrealistic. They presume that the entire cost of health insurance in the United States can be transferred from employers to employees and can become the workers' taxable wages. The United States is now unique in the large number of group contracts wherein workers' premiums are assumed by employers,\* but the opposite extreme is never true. In every country, basic health insurance is a form of social solidarity, with premiums shared by employers and employees. It is part of a package of social security programs, wherein the employers' total payments are at least one-half, occasionally (as in Belgium and French) two-thirds or three-quarters. If the employer's contribution for health insurance is only half or (as in Switzerland) even less, he compensates by paying a much higher share of the payroll taxes for other benefits.<sup>15</sup> The employer's assumption of a larger or smaller share of the premiums is not an option, resulting from deductions under laws taxing business, as an American might think. Rather, the shares by employers and workers of social security and health insurance costs are planned as a package.

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\*The only other significant exception among developed countries at one time was Italy. Employers paid nearly all the national health insurance premiums and most other social security payroll taxes. The burden was thought to be a disincentive to employment and capital accumulation. During the late 1970's, the national government began to subsidize the sick funds from general revenue, instead of continuing to raise the payroll tax on employers. The situation was a principal reason for abolishing national health insurance during the 1980's and instituting a national health service paid for by general revenue.

Actually, the entire issue in the United States may have been invented during classroom exercises and may be insignificant in reality. The National Health Care Expenditures Study found that only one-third of all group health insurance in 1977 were paid for entirely by employers; in two-thirds, workers shared the premiums. Because American health insurance coverage is thinner than foreign benefits, the average total premium was low by world standards, viz., only \$590.50 for the average employee in a firm with employment-related insurance.<sup>16</sup> (The precise distribution of shares in payment of premiums depends on the contract in each firm, and many versions exist. The Blue Cross Association has not attempted to count the many different splits. In most other countries, the rates for employer and worker are standardized for all such funds throughout the nation).

Even if the "tax subsidy" for part of the employer's purchase of health insurance is reduced, the many transformations predicted from this "quick fix" would not occur.\* The amount of health insurance would not be reduced, patient cost-sharing would not increase noticeably, utilization of medical services would not be reduced (either because of cost-sharing or for any other reason), and health care prices would not drop. If the employee rather than the employer pays premiums, the union insists that the workers' wages are increased by the amount of the premiums, and the employer substitutes the wage increase for the premiums in his business costs. In fact, the union may ask more, if the higher wages are taxed; so, a change would cost the employer more. The employer would deduct the premium from wages, add his contribution, and send a single check to the carrier just as in a noncontributory arrangement. So, nothing would change from the perspective of the carrier. The only true change would result from outlawing all group policies -- even the contributories -- and forcing all carriers to negotiate with citizens directly in sales and in

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\*Tax exemptions in other fields produce diverse and often unexpected results, sometimes larger and sometimes smaller than intended, and often perverse. One can theorize in advance that a revision of tax rates and exemptions should produce a result, but many predictions don't come true. Often it is difficult to identify exactly what happened retrospectively.<sup>17</sup>

underwriting. The resultant confusion would reduce "overinsurance" and increase cost-sharing, as in the free-market days before the creation of Blue Cross during the 1930's. But banning group underwriting does not sound like the freedom and competition espoused by the New Utopians. Welfare bargaining, group insurance, and high employers' contributions are the American labor movement's substitute for national health insurance, and the labor movement will give it up only if a full-scale NHI is enacted.<sup>18</sup>

Requiring patients to pay. Another conservative target today is first-dollar coverage. Only patient cost-sharing will supposedly make him conscious of values and interested in shopping; only then will providers become efficient and economical. Some critics propose a very high deductible with coinsurance thereafter.<sup>19</sup> Some proposals are ingenious, such as insurance paying a variable indemnity selected by the patient in advance, according to the costliness of the hospital he and his doctors prefer. In such an arrangement, persons electing the more expensive hospitals and policies receive higher indemnities, but since the spread between indemnity and hospital charge widens, they pay more out-of-pocket. Supposedly persons have an incentive to pick cheaper hospitals or to bargain with the more expensive ones. No hospital could count on coverage of its full costs from the insurance policies alone.<sup>20</sup>

But whenever cost-sharing is enacted abroad, the patients, carriers, and providers act out of a rational economic self-interest not anticipated by armchair theory. The carriers compete for the business of insuring the cost-sharing, nearly every citizen buys the supplementary policies, the hospitals and doctors send their bills to the principal third party, and the result is the same third-party coverage and premiums as in a single comprehensive arrangement. American critics contend that market discipline requires out-of-pockets by the patients, but the only way such a "free market" can be created is by making insurance of the cost-sharing illegal, a greater interference with economic freedom than any present regulation. Three attempts by conservative governments of France to forbid the mutuelles to insure the cost-sharing failed: the Council of State declared two

such decrees an unconstitutional infringement on free contract during the 1960's; the third attempt in 1980 was ultimately a dead letter, since reimbursement was a direct relation between the mutuelle and its subscribers, and there was no way the government could touch it. Several mutuelles also have covered the cost-sharing by giving the care themselves, through their own physicians and health centers, like an HMO. They bill the official caisses for the reimbursement due the patient under the national health insurance law, and the patients' subscriptions to the mutuelles cover the rest without additional charges.<sup>21</sup>

The Netherlands illustrates how an assumption of paid-in-full coverage can dominate the entire insurance market -- although not for every customer, if options exist. Holland is the only European country with substantial voluntary commercial health insurance: compulsory NHI applies to everyone up to a certain income level, and the rest (about 30 per cent) must buy policies from the companies. Since the official scheme has no cost-sharing for inpatient hospitalization in general wards and for physicians' fees, the companies feel they must offer paid-in-full too, lest the upper classes voluntarily join the sick funds. Since the policies offer private rooms and since the employers do not contribute as much as they do to the statutory sick funds, the companies' premiums for such coverage must be very high.

The companies do not like payment in full. With a history and business practices much like the British companies just across the Channel, the Dutch companies have long used deductibles to combat moral hazard in fire, cargo, shipping, and other subjects. They fear that payment-in-full for health will result in over-utilization. So, most of their policies include small deductibles and small cost-sharing, in return for lower premiums. Since payment-in-full is the norm in the country, the cost-sharing is much smaller than in the United States. An exception is a policy introduced by the insurance companies during the late 1970's, with a very high deductible and lower premiums. The policies take advantage of a clause in the income tax laws allowing deduction of medical expenses from taxable income. No research has been done about choice of policies, but apparently self-selection

results: the healthiest persons pick the policy with the highest deductibles and lowest premiums; the higher utilizers pick the policies with complete or nearly full coverage and higher premiums. No-one is forced to share costs; but market theory requires it.

Judging from Swiss experience, cost-sharing can be made obligatory and uninsurable only as a condition for a government grant. Swiss sick funds have depended on premiums from the beneficiary alone; they suffered a financial crisis during the 1930's. The national government agreed to give subsidies to the sick funds, provided that the sick funds collect additional money from the subscribers whenever they visited doctors. The sick fund pays the doctor's fee and then bills the patient for a deductible and coinsurance. The method aims to discourage unnecessary use of medical services and aims to conserve the national government's money. The sick funds are not allowed to offer paid-in-full policies with higher premiums; the extra revenue from the patient is supposed to enable the national government to reduce its subsidy. If the Swiss sick funds did not need government grants, they could do as they like, as in France.<sup>22</sup>

#### LESSONS FOR THE UNITED STATES

In every country, hospitals have always been part of the world of religious and charitable establishments, not part of the world of business firms. On the other hand, doctors have often been businessmen in their economic behavior. The hospital-type arrangements created by the doctors -- small private clinics and proprietary hospitals -- have often behaved like for-profit business firms. Trying to persuade the nonprofits to behave like proprietaries in their internal affairs is inconceivable abroad and unlikely in the United States, because of their traditional commitment to protect the unfortunate. Normally, the nonprofits and proprietaries are rivals, and the systems of payment and planning are biased towards the nonprofits. In the only European country treating them entirely alike (i.e., West Germany), the proprietaries recognized in the official plans behave like the nonprofits.

Hospitals abroad have been social institutions, essential parts of communities. The problem has been to stabilize and strengthen them, to avoid risky and unstable financing.

Insurance is an agreement between someone facing a risk and a company that handles money. But health care raises problems for the subscriber and introduces a provider into the transaction; both find the traditional insurance mechanism inadequate. Subscribers want whatever treatment they need, not a fixed cash indemnity. The providers that give care (particularly the hospitals) commit themselves to considerable fixed costs and want guarantees of payment.

Health insurance is eventually replaced by prepayment of health services. If private nonprofit funds lack the levels of premiums and breadth of coverage to pay for the facilities, the providers press for government financing from general revenue. The prepayment system then produces a permanent obligation to raise enough premiums or taxes to maintain the hospitals and other facilities. Once such a prepayment or public financing system is in place, no significant political force favors a reversion to traditional insurance methods. Therefore, the problem is how to make the new system more efficient, and how to control providers' costs.

Health prepayment -- like all social security -- accumulates money from both employer and employee. Payment is never shifted entirely to the employee, unless the employer in return picks up a much larger share of other social security payroll taxes.

In a free economy, insurance companies and prepayment funds offer and most of the public voluntarily chooses high coverage, even with high premiums. People would rather play safe. Requiring every insured patient to pay some costs and requiring very high deductibles can be accomplished only by laws that infringe on freedom of contract so drastically that they are probably (in the United States) unconstitutional.

## FOOTNOTES

1. I described their close connection to the European churches in Glaser, Social Settings and Medical Organization (New York: Atherton Press, 1970), Ch. 2.

2. Many histories of individual hospitals have been published in Europe, and several describe organizational housekeeping at various stages. I have summarized much of this information in the national monographs that accompany this volume. Almost all comprehensive histories of hospitals concentrate on clinical and architectural matters. Two histories with much financial information are Maurice Rochaix, Essai sur l'évolution des question hospitalières de la fin de l'ancien régime à nos jours (Paris: Fédération Hospitalière de France, 1959); and Brian Abel-Smith, The Hospitals 1800-1948 (London: Heinemann, 1964).

3. Bruce Steinwald and Duncan Neuhauser, "The Role of the Proprietary Hospital," Law and Contemporary Problems, Volume 35 (Autumn 1970), p. 819.

4. I have pieced together the comparative history of health insurance from many sources, since no single overview exists. A good history of social security ideology and policy -- including some references to health -- is Gaston V. Rimlinger, Welfare Policy and Industrialization in Europe, America and Prussia (New York: John Wiley, 1971). Among the very few histories of health insurance in a country are Horst Peters, Die Geschichte der Sozialversicherung (Bad Godesberg: Asgard-Verlag, 1959); and Paul Biedermann, Die Entwicklung der Krankenversicherung in der Schweiz (Davos-Platz: Buchdruckerei Davos, 1955). A good history of health insurance and health financing in the United States is Odin W. Anderson, The Uneasy Equilibrium (New Haven: College and University Press, 1968). Some very revealing comparisons of the Anglo-Saxon and continental European (especially German) philosophies and methods were made when Britain enacted its NHI law. Summarized in R. W. Harris, National Health Insurance in Great Britain 1911-1946 (London: George Allen and Unwin, 1946), Chs. II-III. The contrasting

traditions in workmen's compensation are described briefly in George Rohrlich, "Comparative Approaches to Work Injury Compensation in International Perspective," in Compendium on Workmen's Compensation (Washington: National Commission on State Workmen's Compensation Laws, 1973), Ch. 6.

5. Only in the two other Anglo-Saxon countries that once shared the liberal tradition with the United States does one even hear of similar proposals. For example, Arthur Seldon (editor), The Litmus Papers (London: Centre for Policy Studies, 1980); and Åke Blomqvist, The Health Care Business (Vancouver: The Fraser Institute, 1979).

6. From the speech of Secretary of HHS Richard Schweiker to a conference of The National Journal, June 1981. He added: "We believe competition will prove to be the single greatest force for controlling prices. . . . Can we create real incentives for consumers to choose co-payments and cost-sharing health plans?"

7. Life Insurance Fact Book (Washington: American Council of Life Insurance, 1981), pp. 13 and 104.

8. For example, "Health Insurance for Older People -- Filling the Gaps in Medicare," Consumer Reports, Volume 41, Number 1 (January 1976), pp. 27-34. A buyer in a typical market would not be assisted by a clear presentation like this article.

9. Marjorie Smith Carroll and Ross H. Arnett, "Private Health Insurance Plans in 1978 and 1979," Health Care Financing Review, Volume 3, Number 1 (September 1981), p. 72.

10. The Americans who believe in the potent effects of cost-sharing assume that the demand for insurance against it would be negligible: Emmett B. Keeler, "The Demand for Supplementary Health Insurance, or Do Deductibles Matter?" (Santa Monica: Rand Corporation, 1976). But if cost-sharing is so oppressive and deterrent why wouldn't patients defend themselves? European experience certainly shows the extensive market for payment-in-full.

11. As in the schemes described by Paul B. Ginsburg, "Altering the Tax Treatment of Employment-Based Health Plans," Health and Society, Volume 59, Number 2 (1981), p. 247.

12. Described in William Glaser, "Controlling Costs through Methods of Paying Doctors," in Stuart O. Schweitzer (editor), Policies for the Containment of Health Care Costs and Expenditures (Washington: National Institutes of Health, U.S. Department of Health, Education and Welfare, 1978, DHEW Publication No. (NIH) 78-184), p. 234.

13. Martin Feldstein, Hospital Costs and Health Insurance (Cambridge: Harvard University Press, 1981), Part 2; and Ginsburg, op. cit. (footnote 11, *supra*). Policy planners in Ronald Reagan's HHS at the time of writing are so persuaded by this scenario that they hope to recommend repeal of the tax deduction. A review of the literature about tax treatment of health costs and health spending, and a summary of possible policies is Tax Subsidies for Medical Care: Current Policies and Possible Alternatives (Washington: Congressional Budget Office, 1980).

14. Essays by Martin Feldstein and Milton Friedman in Michael J. Boskin (editor), The Crisis in Social Security (San Francisco: Institute for Contemporary Studies, Second edition, 1979), pp. 17-30. Feldstein might accept government administration of social security, provided that it be managed like private insurance, wherein benefits depend on accumulated contributions.

15. The schedules of contributions are in Social Security Programs throughout the World (Washington: Social Security Administration and U.S. Government Printing Office, annual). The principal patterns are summarized in Martin B. Tracy, "Payroll Taxes under Social Security Programs: Cross-National Survey," Social Security Bulletin, December 1975.

16. "Employer and Employee Expenditures for Private Health Insurance: Data Preview 7" (Washington: National Center for Health Service Research, 1981).

17. Papers about many fields are in Henry J. Aaron and Joseph A. Pechman (editors), How Taxes Affect Economic Behavior (Washington: The Brookings Institution, 1981).

18. The central role of welfare bargaining in American labor strategy -- and the impossibility of reversing it without equivalent benefits -- is evident in Raymond Munts, Bargaining for Health: Labor

Unions, Health Insurance, and Medical Care (Madison: University of Wisconsin Press, 1967).

19. Feldstein, op. cit. (footnote 13, supra), Ch. 9.
20. For example, Joseph P. Newhouse and Vincent Taylor, "How Shall We Pay for Hospital Care?", The Public Interest, Number 23 (Spring 1971), pp. 88-89.
21. William Glaser, Paying the Hospital in France, Ch. II, pp. 4-11; Ch. XI, pp. 2-3; and Ch. XIII, p. 12.
22. Botschaft des Bundesrates an die Bundesversammlung zum Entwurf eines Bundesgesetzes betreffend die Änderung des Ersten Titels des Bundesgesetzes über die Kranken- und Unfallversicherung (Vom 5 Juni 1961), Number 8251, pp. 36-38.



## CHAPTER IV

### MARKET STRUCTURE AND COMPETITION

Some Americans argue that weaknesses in health services can be corrected only by introducing more free market competition. Patients before illness should shop for financing arrangements that best satisfy their preferences; in anticipation of illness or once need arises, they should shop for hospitals and doctors. Once they meet insurers and providers, they should bargain over prices and services. On the other hand, hospitals and other providers should compete to offer more benefits at lower prices. Presumably many would follow principles of comparative advantage, concentrating their talents and capital in fields where they can work most efficiently. Services to meet a demand would grow; services that are demanded less often would contract. Insurance carriers would compete in performing the brokerage function most efficiently, designing benefit packages at economical prices.

These critics argue that present American health financing destroys competition. Hospitals are guaranteed their costs under many prepayment and insurance arrangements. Doctors are allowed to collude rather than being forced to compete in prices and services. First-dollar coverage eliminates patients' price consciousness. Carriers are allied with hospitals and doctors instead of seeking the most favorable bargains. Market failures are worsened by government regulators, who make allocation decisions that differ from what consumers might do, and who are easily captured by the providers.<sup>1</sup>

The American critics presume that hospitals under national health insurance and under general government grants suffer even more seriously from "market failure" and misallocation of resources. Therefore, they oppose enactment of national health insurance and a national health service. They accept only a particular image of a market structure.

The following pages will describe the kinds of competition encountered in hospital affairs under national health insurance and general public financing in the other developed countries. I will report that certain types of competition survive and others disappear. I will suggest that certain kinds of economic competition are hard to perpetuate in health services, no matter what the system.

#### CONSUMERS AND CARRIERS

Coverage selected by consumers. Every country once had only voluntary coverage. Even when prepayment became compulsory for many workers, entire social classes (professionals, shopkeepers, farmers, the retired, the unemployed) were left to their own arrangements. Some bought private insurance -- often simple indemnity plans -- but many did not. Many of these lacked foresight or lacked carriers interested in accepting them. An unknown number self-insured. Government had to come to the aid of the hospitals with charitable help for the poor.

Several political forces in each country pressed for wider compulsory coverage, viz., the trade unions (wanting guaranteed protection for their members), the sick funds (wanting a large revenue base), the hospitals (wanting guarantees of income), and government finance officers (wanting fewer demands for charity care paid from general revenue). Political parties of both the Right and Left might have disagreed about other social security laws but united in favor of expansion of national health insurance (once it was initially created) and enactment of national health services. Employers did not like to pay premiums -- they always refused any share in Switzerland -- but resisted health insurance less stubbornly than other social security programs, since they benefitted from rehabilitation of their workers. (The only serious dissenters were the doctors, who feared the sick funds would dominate them.)

Perhaps a few self-insurers would have preferred not paying premiums, but the histories of European health insurance do not record substantial numbers of resisters. A few countries with national health insurance still have less than universal coverage, but nearly all the remaining persons buy private insurance. For example, those remaining

without compulsory or voluntary coverage are 1 per cent in Holland and in Germany, fewer than 6 per cent in Switzerland. Therefore, the desire for health insurance seems strong and widespread -- even if the consumer must pay much of the premiums -- particularly in the societies with a tradition of mutual aid.\*

Awareness of costs. No-one has ever thought of health insurance as "free," since the workers have always paid payroll taxes or premiums. The amounts are substantial: in Holland in 1979, the worker paid 4.1% of his wage for medical care benefits and the employer added 7.16%, not including disability cash benefits; in West Germany, the worker paid between 5.5% and 6.8% (depending on sick fund) and his employer matched it.<sup>2</sup> If overutilization of medical services results, it is not because the European subscriber thinks he is getting a "free good" from his employer or government, as American critics think. Rather, the subscriber may overutilize because he "wants to get his money's worth," after having paid a lot. Therefore, the problem is not to levy yet more premiums on him but to introduce utilization disincentives and controls into the delivery system.

Catastrophic policies. No foreign medical care insurance -- whether compulsory or voluntary -- has ever been designed for catastrophic care alone. The sick funds began with death benefits and disability benefits, to insure against catastrophes. But when they offered medical care benefits, they covered the smallest risks, viz., visits to doctors and medicines. Not until later did they cover hospital costs. The bill for catastrophic care is very recent, due to modern technology and the patient's recent ability to survive a catastrophic illness long enough to incur treatment costs. A financial problem of NHI in many countries has been how to pay for the catastrophic cases and the long-term hospitalizations; these are reasons for government subsidies of

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\*Whether any of the Anglo-Saxon countries -- with their insistence at one time on self-help for everyone -- could have achieved such coverage is uncertain. By 1956, voluntary hospital insurance and limited public benefit programs had plateaued at two-thirds of the population in Ontario, the hospital managers and governments lost patience, and full public benefits programs were enacted in Ontario and throughout Canada, bypassing the puzzle about how to sell more insurance.

the sick funds. I have never heard abroad any proposals to give up the rest of NHI just to have catastrophic coverage.

Payment in full, cost reimbursement. Once European health insurance paid indemnities, and the sick funds found doctors willing to treat at those rates. (Until so many became affluent after World War II, many doctors in every country were willing to "accept assignment" at low rates.) Thus started payment in full by a third party. When sick funds began to pay for intramural care, many hospitals and the funds agreed to paid-in-full daily charges. Until practices were standardized, many doctors and hospitals expected additional out-of-pocket by the patients; or, the patient paid the provider and recovered his indemnity from the sick fund. But the trend was toward payment-in-full by carriers and direct third-party payment.

American critics assume that payment-in-full by a carrier means satisfaction of whatever the hospital or doctor demands, thus enabling them to run up costs without limit. This has never been true outside the United States, because the sick funds had limited money and no free source. In every other country, the sick funds were usually independent of the hospitals and doctors; if they wanted to help the hospitals cover their operating costs, they did not merely accept the hospitals' claims but insisted on independent investigations. When modern technology and modern staffing caused hospital costs to mount -- the upturns occurred at different times abroad between the late nineteenth century up to the mid-twentieth -- negotiation and regulatory mechanisms were imposed on hospital rates. Some of these methods were permissive, but all had finally been tightened by the 1960's and 1970's. The sick funds and hospitals did not negotiate over the price of every individual case, but they did bargain over contractual conditions and over charges. Or, they deferred to neutral regulators. Later chapters will describe details.

As I said in the last chapter, some Americans have argued that cost-sharing by the patient is indispensable for the operation of a genuine economic market. However, in a truly free market, the carriers are motivated to offer supplemental policies to cover the cost-sharing. Most citizens prefer the security of full coverage and

buy the supplementary or more complete policies in France and Switzerland, the two countries where NHI retains cost-sharing. (Complete first-dollar coverage is not widely sold in Switzerland, but the pattern of purchases by most persons comes close.) As a result, the difference between the countries with and without cost-sharing for basic benefits is very small: the total packages in France and Switzerland are almost as complete and almost as expensive as in (for example) Holland and Germany. But, of course, a system with cost-sharing provides options: in France and Switzerland, minorities of persons choose to self-insure the out-of-pockets and do not buy the supplementary policies.<sup>3</sup>

Eventual standardization and decline of competition. Health insurance seems to be one of the markets wherein consumers look for the same basic product and all providers eventually offer it. Once European sick funds differed widely in their list of illnesses covered, in their indemnities, and in their commitments to pay providers' charges in full; therefore, they could vary widely in premiums. By now, in every country, all offer the identical basic benefits. Trade unions pressed for more complete benefit packages; doctors and hospitals wanted payment for more services. The NHI laws and regulations listed broad categories of benefits that had to be provided by carriers in order to receive the payroll taxes. The specific list of benefits had to be agreed on by all sick funds, since they joined in a common front when bargaining over charges with the medical association and with individual hospitals. A completely fluid market was not possible.

In many countries, a person has the option of several sick funds, and the carriers compete, by methods other than offering lower benefit packages at lower premiums. Some have more free money than others, because they have fewer retired members or because their subscribers have higher incomes. In countries with standard payroll taxes (such as Holland), sick funds cannot try to attract more subscribers by offering lower premiums; in countries where the funds can set their own premiums (such as certain RVO-Kassen in Germany), some charge lower rates for the same benefits. But sick funds have come to judge that subscribers want more benefits rather than lower premiums, and

additional benefits are a common offer by the more prosperous funds. They include dental benefits, more generous drug coverage, longer hospital stays, convalescent trips to spas, prostheses, and so on. Sick funds compete in presenting an image of efficiency: they usually process bills very quickly. In some countries (Belgium today, formerly France and Holland), they compete for loyalties of subscribers on non-clinical grounds, viz., some are Catholic, others Socialist, others secular and Liberal, and so on. In practice, NHI has become so standardized that the proliferation of funds with special identities has become obsolete, and many merge (in Holland, Germany, and Switzerland), in order to spread the economic burden of the aged over a larger base and in order to save administrative costs.

As long as sick funds bargain collectively with providers over charges, none can gain preferential treatment for its members by offering higher fees for the same service. One of the few exceptions in any NHI program is the Ersatzkassen for middle-class Germans. Their subscribers pay higher premiums than members of the basic sick funds (the RVO-Kassen), and they have refused to join the others in negotiations with the medical profession. They offer slightly higher fees, to the delight of the doctors and the indignation of the RVO-Kassen. However, the Ersatzkassen protect themselves financially by joining the others in a common front against the hospitals and pay no more than the negotiated daily charge.

Freedom to choose among sick funds has always varied. In countries with several funds, such as Germany, the wage worker usually (not always) is committed to the sick fund organized at his work place; his employer's contributions go there. Associations of these many small funds maintained standards and helped their administration. The trend among these smaller funds is toward mergers, resulting in greater uniformity in premiums and in benefits. Many sick funds are sponsored by trade associations, such as craftsmen and schoolteachers. Even when the person might have a choice, he tends to join the fund of his in-group rather than shop like a "rational consumer." Comparison-shopping among subtly different packages of premiums and benefits is too difficult for the ordinary person, although his attention can be attracted

by distinctive new benefits, even at higher premiums. Switzerland is one of the few countries where the carriers are insurance companies projecting alike a businesslike image free of particularism. Smaller Swiss funds are strained as their membership ages and as hospital costs rise, and they are absorbed by the bigger ones.

#### HOSPITALS

Competition to survive. In most communities in the world, the patient's choice of hospital is simple: there is only one in the area. Once everyone went there, including the injured and the acutely ill. Now they are always small establishments with simple equipment. Since they lack the volume to support a full-time salaried staff, their medical care is usually given by the local general practitioners and whatever specialists are in office practice nearby. They usually have many elderly patients in their medical department, with a few younger and short-stay patients in surgery and obstetrics. Complicated acute patients are given emergency care in these small hospitals and often are then transferred to a more advanced establishment in the nearest city. This referral hospital is usually the only one of that level of technology and staffing in the district. The smaller hospitals in the world are becoming primarily extended care facilities, either officially or in practice.

As one flips through hospital directories in every country, it appears as if most are these two kinds of monopoly: the only one of any kind in a small town; or, the only acute-care facility in a district. If a small-town patient wants a choice, he must travel to a city, and some do. Each small hospital has a monopoly in its market, but its problem is low utilization. Many face a constant political competition with other hospitals over support from governments and sick funds who want to close them as unnecessary and wasteful. The managers', boards', and doctors' response is that of the political rather than the economic marketplace, viz., arousing the community and the local politicians to force governments and sick funds to keep paying. Left to an economic marketplace as defined by a proprietary

hospital management, the smallest hospitals would be doomed. However, often a deal is struck, converting them into nursing homes or extended care facilities, with modest levels of staffing and technology. Costs can be covered by charging the residents a share of their pensions and by drawing from special government benefits programs for the elderly infirm.

Competition to grow. Many American hospital managers and owners reason like businessmen. They think of the hospital as having entered a market with a considerable investment, a large and nearly fixed wage bill, and some variable costs; the hospital must attract a constant flow of inpatients and outpatients (preferably highly profitable ones) to cover the fixed and variable costs; the greater the volume of business, the lower the unit costs, and the greater the hospital's capacity to expand in equipment and personnel; expansion in turn is a challenge to find more patients. After some point in the growth, the economies of scale are passed and the hospital becomes difficult to administer.

Foreign hospital managers think this way when they are starting a new facility, whether it is nonprofit or proprietary. During their first years, regulatory agencies under national health insurance give the managers of nonprofit hospitals considerable discretion in writing their budgets, setting their daily charges, and finding patients. The new hospital finds its patients by the efforts of its specialist staff, who got referrals while serving in their previous hospitals; and by publicity. New outpatient departments attract patients to come back to the same specialists, for both ambulatory and impatent care, provided they are free to choose. After a few years, the regulatory agency subjects the new nonprofit hospital to the usual close review of budgets, rates, and utilization, and the period of searching the market for patients ends. The cycle has not been so common in recent years, since only a few (such as Holland) have had extensive construction of new hospitals. (In Holland, the new ones usually have resulted from mergers of several old ones, and the old doctors and their patients stay on.)

Proprietary hospitals abroad have greater freedom from regulators. To make up for fewer guarantees of their operating costs, they

have greater freedom to seek patients. Whether it is a new nonprofit starting up or an established for-profit trying to survive, the key to marketing is the appointment of specialists who will attract patients. In the case of some large proprietaries in Europe, only doctors who bring in many patients will get renewals of their contracts, since the establishments' total operating budgets and investments depend not only on the hospital charges collected from patients but on a share of the physicians' fees.

Nonprofit hospitals in Europe and Canada do not compete vigorously to take business away from each other. They are all reviewed by the rate regulators, sick fund negotiators, or government granting agencies (according to the practice of that country) who would resist the added costs without commensurate improvements in care. The public authorities would have to pay a larger volume of money to the expanding hospital because of its greater number of patient-days and would be pressed to pay higher unit costs to the losing hospitals to cover their fixed costs. If an aggressive nonprofit hospital found many more admissions and patient-days by itself, the public monitors would be suspicious that the work was manufactured to earn money and would probably refuse to pay last year's overruns and next year's predicted number of patient-days. Inpatient utilization measures in Europe and in most of Canada are stable nowadays; the populations of Europe no longer grow, everywhere efforts are made to reduce stays, and in most countries more work is being done extramurally. The sector that the public monitors miss is the outpatient department, since its records are mixed into the total hospital budget. If nonprofit hospitals try to increase work, it is often in the outpatient department.

Proprietary hospitals have every incentive to take patients away from the nonprofit hospitals. Once this was their raison d'être: patients did not like the large public wards and older buildings of the nonprofits, and the NHI laws required the sick funds to give their patients freedom of choice. When the nonprofit hospitals' chiefs of service had private clinics, they had an additional incentive to hospitalized patients privately, since then they collected private fees. However, during the 1960's and 1970's, in much of Europe the nonprofit

hospitals became more attractive, they offered private rooms, and chiefs gave up their private clinics to spend all their time in the hospital. Some proprietary hospitals still survive in Europe, and they are reviving in England.

A competitive market depends on a particular structure and rules. Once circumstances strengthened the hands of the private clinics and large proprietary hospitals in Europe, but the payment system now hampers them. Many are not admitted to official hospital plans (for example, in France and in Germany) and are not granted a full daily charge comparable to the nonprofit hospitals by the regulators (in France) or by the sick funds' negotiators (in Germany). They must negotiate whatever charges they can get from the sick funds, who do not have to be generous, since enough nonprofit hospitals and enough proprietaries have been admitted to the plans. The proprietaries who are outside must self-finance their investments rather than get loans and grants from public funds. This is a problem, because of the rapid obsolescence of modern equipment and because new devices are needed to attract the doctors who can attract patients. Nevertheless, the European proprietaries have been able to survive by offering more personal care, by guaranteeing treatment by a personal senior physician (rather than by a large staff), and by concentrating on acute short-stay conditions. They compete for only part of the full patient market.\* Patients pay no more than the minimum cost-sharing in a proprietary in the official plan but are reimbursed by the sick funds and/or by private insurance policies only in part in the other proprietaries.

In business markets, new entrants are encouraged to innovate and to attract resources and customers from the established firms. However, established hospitals resist blandishments from the proprietaries, since the nurses may transfer more quickly than the patient flow, intensifying shortages. For example, a new private hospital will

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\*As in the United States, European proprietaries compete for patients by advertising in the media and distributing attractive brochures. In all the photos, hardly anyone -- patient, doctor, or nurse -- seems older than forty years. As in the American brochures, nurses cuddle babies, animated young domestics carry gourmet meals, and staff members smile at each other.

be licensed by a District Health Authority in Britain's National Health Service only if it will not "prejudice" operation of the NHS hospitals by attracting away their employees and other resources. Therefore Britain's private hospitals are careful to offer no more than the NHS contracts and wages.<sup>4</sup>

Established hospitals compete for professional prestige. Very few European and Canadian hospitals are managed like business firms. They originated as religious charities. During the nineteenth and twentieth centuries, they became the workplaces of professionals. They are not like factories or merchants, who can move about easily, expanding and going bankrupt flexibly, but they are integral community institutions, often staying in the same locations for centuries and serving generations of nearby inhabitants. Managers think long ahead and do not merely respond to the market demand of the moment. Managers try to maintain stability for the organization generally, even when selected programs are starting up and growing.

The modern history of European and North American public and voluntary hospitals records a steady search for methods of matching costs, in the face of mounting demands for improved technology, more expert staff, and normal working conditions. Various guaranteed prepayment methods evolved in Europe (usually national health insurance), in the Anglo-Saxon countries (general Treasury financing in Britain and Canada), and in the United States (a potpourri of general Treasury financing, employer-paid prepayment, and subscriber-paid commercial insurance). The nation-wide payers in Europe, the province-wide payers in Canada, the medical profession, and existing hospital owners have brought about stability in hospital markets. The key figures, the medical chiefs of service, do not like risky and unpredictable settings, as in competitive business firms. The hospital leaders (doctors and managers) and the payers have disputed the magnitude of gradual trends; but the hospital side has avoided short-run leaps in market share and spectacular changes in function, since drastic disruption of the hospital market structure is disturbing to everyone.\*

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\*A planned and orderly rearrangement of hospitals is being attempted in Britain's National Health Service during the late 1970's

Once service chiefs gained power and fame from controlling many beds, since they ruled many subordinate doctors and nurses, and since the lives of many patients depended on them. The medical and lay directors of very large hospitals were famous and powerful. So, they gained from obtaining and retaining a big share of the market in the large cities. However, these motives have become obsolete. In most countries, clinical services have become smaller. After reorganization and reconstruction, the principal hospitals often become smaller.

Sheer size -- i.e., a large share of the market of ordinary medical consumers -- is now much less rewarding in professional prestige than skilled performance of specialized work. Once only the chiefs in the teaching hospitals did advanced work, but the spread of technology and skill makes it feasible in all urban hospitals. Therefore, hospitals throughout Europe and North America compete for the means of modern professional prestige: investment money and the specialist physicians who can use the new techniques. The two means for professional prestige go together: in order to attract very skilled specialists and give them enough practice, a hospital (particularly a teaching hospital) must obtain new equipment, either through official sources or through private donations.

The proliferation of specialized clinical programs is more expensive than mere competition to expand in the treatment of ordinary cases. Most European countries and Canada try to restrain their number by setting priorities and controlling purchases; the methods are described later in this monograph. The government planners and sick funds prefer a division of labor in advanced work. Hospitals are becoming adjusted to this: the reputation of each urban hospital depends on a few outstanding fields as well as good basic care in the others.

Because of their difficulty in getting investment money -- even in the few countries permitting self-financing under the daily

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and 1980's, instead of one induced by a struggle over market shares. Old hospitals are phased out as new ones are phased in, mergers result, patients and staffs suddenly must change their normal sites, and new relationships are made and then remade. The instability is proving strenuous.

charge -- the proprietary hospitals usually do not try to compete with the nonprofits in the advanced specialties. The proprietaries seek a larger market share of the simpler acute cases and leave the challenging complicated cases to the technically advanced nonprofits.

#### PHYSICIANS

Doctors compete for professional status and for money, in ways that affect the operations of hospitals. Careers abroad are more structured than in the United States, the prizes are scarce, young doctors must struggle to win at certain turning points, and they must be careful not to fall off the ladders. Several countries -- and particularly France -- have formal competitions judged by committees, to win every leading job in the nonprofit hospitals and in schools of medicine. Until he reaches his final goal, the young doctor must constantly compete for higher grades, personal sponsorships, and professional reputation. The job market is nationwide, so the young hospital doctor must please his boss to rise anywhere else.

The prizes in order of desirability are:

1. Professor in a medical school. Usually also carries the rank of chief of service in the teaching hospital. Once the supreme position in every country's medical profession, since the grand patron shaped the intellectual content of his specialty, controlled a large service with many junior doctors, could place his proteges in key jobs throughout the country, served on committees to fill jobs in his specialty throughout the country, controlled research projects in his home base, and earned a large outside income from private practice. The role has become less powerful and less affluent, since services have been reduced in size, opportunities for private practice have been reduced and (in a few countries) have been replaced by full-time salaries, the diffusion of technology enables all urban hospitals to practice advanced medicine, and less hero-worship is conferred on professors. But the jobs are still prized by young doctors, and the best compete to enter and rise in the staffs of the teaching hospitals. Becoming the deputy to the chief

guarantees success for life; he directs all clinical work in the service and is a leading candidate for all professorships and leading positions as a chief anywhere in the country.

2. Chief of service in a leading nonteaching hospital. Because of the spread of superspecialties, technology, and expert staffing into all urban hospitals in every country, the jobs have become very attractive. In most countries the chiefs have rights of private practice within the nonprofit hospital, in addition to high salaries. Every young doctor now must take some postgraduate work in a teaching or nonteaching hospital. The aspirants for specialties must stay on and rise. Losers eventually go into office practice, with or without specialty credentials. Winners eventually become chiefs in hospitals; the more successful the competitor, the better his affiliation. Even after becoming a chief, the doctor may try to win the competition for a better opening elsewhere.
3. Affiliation with an attractive proprietary hospital. A few opportunities for full-time practice exist in a few European countries, such as Germany, France, and Switzerland. Some young specialists switch from the slow career advancement in the nonprofit hospitals to a partnership or staff appointment in a proprietary. They may have to bring money, to add to the investment pool. Advantages are a more egalitarian staff structure, less regulation by government, unlimited rights of private practice, and use of the hospital as a private office instead of maintaining one's own. Winning acceptance by the partnership or owner is just as competitive as winning promotion in the nonprofits; to stay on, the doctor must bring in business. A drawback to freedom is the uncertainty over the future of the proprietaries.

Some effects on the hospital from the competitive career structure in medicine are:

1. Discipline and hard work within the medical staffs in the nonprofit hospitals. While the unionization and higher salaries during the 1970's in all countries gave the junior doctors more security, career advancement still depends on competition and pleasing one's boss. (The leaders of Britain's rebellious junior hospital doctors

during the mid-1970's discovered this sad reality when they sought to rise into consultantships later.)

2. Doctors seek out the hospitals with the more advanced technical levels, and the hospitals try to appoint those chiefs and juniors who are most skilled in the new methods. The nonprofits therefore now are under pressure to keep modernizing, while they were not in the past. The nonprofits are more technically advanced than the proprietaries, because their physicians have different motives and because they have more investment sources.
3. The nonprofit medical staff is not under pressure to bring in many new inpatients and to whip them in and out quickly, in order to earn income for themselves and for the hospital. The establishments are more stable, with a less frenetic work pace than in the United States. In contrast, even the American nonprofits try to increase their market shares by competing for the doctors who can bring patients in and out quickly. Both the American doctor and the hospital profit from frequent admissions, short stays, and high turnover. European proprietaries work in the American fashion, seeking the most popular doctors and treating patients quickly.

European outpatient practice in the nonprofits differs from inpatient practice. In several countries, hospital managers welcome chiefs with a flourishing ambulatory practice, and doctors seek openings in hospitals with such opportunities. The OPD brings flexible extra income to the hospital and extra fees to the chiefs.

The American literature about markets presumes that the customer pays the provider and can withhold payment for unsatisfactory performance. The critics object to automatic third party payments and prefer insurance that pays the patient cash benefits. By these standards, Europe and Canada are suffering from hopeless market failure. In general, the hospital doctor and office doctor are guaranteed payment of a predictable amount for nearly every medical service. Third party payment is almost universal under national health insurance and is becoming common under private health insurance. Even the last major holdout on behalf of cash benefits, France, is now adopting third-party payment of the office doctor in actual practice.

The American patient should have more bargaining power over his doctor. In many instances, he must pay cash and get reimbursed by his carrier. Even when the carrier pays the doctor, the American patient can create inconvenience and delay by not filing a claim form or by entering mistakes. Once the cash nexus seemed to make the doctor defer to the patient, since physicians' incomes were low. Doctors even went to see patients at home. However, the expertise in modern medicine has made the doctor awesome, patients are very anxious and dependent, and the American patient obediently arranges payment. His economic power is forgotten.<sup>5</sup>

#### REORGANIZING THE DELIVERY SYSTEM

One school of American critics concedes that existing health delivery suffers from market failure and cannot be made competitive by manipulation of the rules about insurance, cost-sharing, and market relations between established organizations. Rather, the health delivery system must be reorganized, by such methods as creating a large number of prepaid groups that guarantee all ambulatory and inpatient care. Their admirers do not think these combinations to be infringements on competition, but as the best method of encouraging competition. The admirers would even favor exempting the HMO's from the anti-trust laws, which would continue to apply to all other providers.<sup>6</sup>

Prepaid group practice is often organized by sick funds in less affluent countries, with limited coverage and funds. The problem is to guarantee benefits for the subscribers without going bankrupt. When European sick funds first offered medical care benefits during the nineteenth century, many signed contracts with general practitioners to provide all care for their members according to a schedule of moderate and predictable pay rates. If the doctor was a free professional working out of his office or home, the payment was often a capitation fee for each subscriber; examples were England, Holland, Germany, and Denmark. Some sick funds created small health centers to house doctors, pharmacists, and others (in Germany, France, Italy, Spain, Hungary, and Poland); in this more organized setting, the doctors were paid salaries.

Often in Western Europe, relations between doctors and sick funds were tense. The panel physicians found the sick funds too domineering and stingy; they feared being converted into salaried employees beneath laymen with limited education and with Left-wing views. The salaried doctors in German health centers fought the sick funds with protests and strikes intermittently during the early decades of the twentieth century. The other physicians not in panel practice protested about their inability to treat every patient; many ordinary GP's outside the panels were impoverished and were forced out of medicine. A principal reason for the rise of medical associations during the twentieth century in several countries was to fight legislative battles against the principle of closed panels.

When national health insurance laws were enacted during the twentieth century in several European countries, the medical association and its allies in the legislature usually obtained a clause guaranteeing that any physician could treat any patient under NHI, and that any patient could select any physician. The original German statute in 1883 had not anticipated the issue, but the German Constitutional Court in 1960 declared any limit on the number of doctors admitted to NHI practice a violation of the Bonn Constitution's protection of the right to pursue any occupation.<sup>7</sup> Therefore, if a closed panel becomes big enough, it infringes fundamental freedoms. Often in the bargaining to write a national contract between the medical association and the sick funds (as in France), the sick funds agree to freedom of practice and promise not to create health centers.

Closed panels survived elsewhere. They became the standard model for the entire country in Eastern Europe, the Soviet Union, and Israel. In Eastern Europe and the USSR, government-owned polyclinics with salaried GP's and specialists give all ambulatory care. The polyclinic often is connected to a hospital like Kaiser Permanente. In Israel, the labor association's sick fund, Kupat Holim, delivers care to almost the entire population through its polyclinics with salaried doctors. Anyone could rely on private practice instead, but few patients do so, and few doctors try to survive entirely on private practice outside Kupat Holim. The fund runs hospitals as well.

Spain and Italy for long had a mixed delivery system, as the American reformers recommend: several sick funds, many polyclinics with different arrangements, some hospitals managed by sick funds. The mixture proved financially weak and too contentious in Italy, and all ambulatory services and hospital care will be paid from revenue of the government during the 1980's.

Among the few examples of HMO's under NHI in any country are the societes mutuelles of France. These prepaid funds were the fiscal intermediaries for all NHI before creation of the official caisses in 1946. While contracts with the medical association bar the caisses from creating health centers, the mutuelles have never been barred. Many have ambulatory health centers (with facilities for GP's, dentists, pharmacists, ophthalmologists, etc.), and a few own and operate hospitals. If a member of a mutuelle goes to such a doctor or hospital, he pays no cost-sharing; its costs are covered by his subscription fees to the mutuelle and by reimbursement of the mutuelle for its medical expenses by the official caisses under NHI.

Four-fifths of the French population belongs to the mutuelles, but most do not use their polyclinics and hospitals. They exercise their freedom to go to the office doctors and the normal public and private hospitals. The official sick funds cover their care, and their mutuelles cover their cost-sharing. Even if they wanted to use the mutuelles' hospitals, there are too few and the member is too far away. Therefore, the medical programs of the mutuelles remain small.

The experience of Ontario demonstrates that giving patients freedom to choose a provider at any time can be fatal to an HMO. Two American-type HMO's have existed at Sault St. Marie and Ste. Catherine. After medical care financing in Ontario was taken over by government, each HMO was supposed to write a prospective budget and receive installments from the provincial Treasury. But every citizen -- and each HMO member -- had the right to free choice of doctor, even if he was outside the HMO panel. The HMO had to pay the outsider's bills from its own money, since supposedly it was relieved of the work. Losses of income while its costs remained fixed caused deficits to both HMO's, and Ste. Catherine had to abandon its format, becoming an ordinary health center housing a group of fee-for-service doctors.<sup>8</sup>

American reformers favor a landscape with different types of delivery method in competition. In practice, it is difficult to maintain an equilibrium for long. For example, widespread health insurance with free choice of doctors prevents HMO's from growing very much. On the other hand, a rush can be motivated in the other direction. During the 1970's, the county councils of Sweden created salaried jobs for doctors in well-appointed health centers. The office doctors must work longer hours and must pay for their office costs. Nearly all young doctors have been going into the salaried jobs, and private office practice will soon disappear.

#### EXPANDING THE MARKET

Competition among providers in a free market is not confined to dividing an effective demand presented by customers. Producers and sellers would be finite in number and size; as one grew, others would decline. Therefore, competitive economies always expand the market through salesmanship, inducing new tastes and educating persons to become new consumers. Modern economies are based on such taste-making, in automobiles and in other goods. Competing automobile makers in every Western country persuaded new customers to "need" their cars and for several years induced owners to replace the cars quickly.

It is hard for competing hospitals and doctors to create new tastes in quite this way. They are supposed to treat illnesses that "really" exist, not persuade members of the public to feel they are suffering from completely new conditions "invented" by the providers. Case-finding might be done by providers who otherwise would be under-employed, but usually it is considered humanitarian and cost-reducing, since it prevents deterioration. Such case-finding does not expand the market but permits it to be served at an earlier stage.

Competition may have the perverse effect of increasing work in the form of more visits to the doctor, for tests and observation. The number of doctors increases in every country and may outstrip the available work, particularly in European countries with stationary populations. The number of patients does not increase, but a larger

number of doctors must earn their livings. Several American economists have speculated about "provider-induced demand," but proof cannot be adduced from macrostatistical analysis.<sup>9</sup> Negotiations between European medical associations and sick funds usually set fees to assure all doctors high incomes, so they don't have to multiply work unnecessarily, even as the medical profession grows.

The analogue for hospitals is to prolong the length of stay, but it is not due to competition for a finite demand from an increasing number of hospitals. Rather, it would be motivated by a desire to earn "profits" from a daily charge designed to cover the year's costs from a predicted number of patient-days. But I doubt whether many European doctors and hospital directors really prolong stays: in fact, stays in every country have steadily diminished. (See p. XII-13, infra.) In most countries with daily charges, payers recapture the providers' profits.

There is one remarkable example of how competition in hospital care can expand the market and increase spending, viz., the spas of Germany. For centuries, many Central European towns have had mineral springs considered helpful as baths for rheumatism, arthritis, gout, and skin disorders; as drinks for digestive ailments; as vapors for asthma; and so on. These towns became resorts for health and recreation. Establishments housed, fed, bathed, and entertained persons. Physicians located in these towns, to supervise the "cures." Gradually the establishments acquired medical, nursing, and domestic staffs and were called "Sanatoria," "Kur-Krankenhäuser" or "Kurkliniken." Now about 12 per cent are nonprofits, owned by associations with many members thought to need the treatments, such as one of the funds for old-age pensioners. About 27 per cent are owned by the city governments or the provincial governments. About 61 per cent are proprietary establishments, owned by doctors or businessmen.<sup>10</sup>

Competition in several ways has drawn more Germans into becoming patrons of the sanatoria. A clientele of the infirm and elderly is not very profitable. The older classes of the rich had supported the fancier spas, but they were destroyed by wars and depression; the new rich preferred modern hospitals close to home for their medication and

the seaside or mountains for their recreation. A younger employed, and more active clientele became the target:

1. The towns had always depended almost completely on the spa business. After World War II, each went all-out, constructing new buildings for dispensing the waters; constructing recreational facilities for younger customers with their families (such as swimming pools, tennis courts, boat docks, and municipal theaters); modernizing and expanding recreational programs (concert series, drama, etc.). Each town publicized its combination of health, culture and fun all over Germany with modern advertisements. Each competed for a maximum share of the new clientele.
2. Within each town, the sanatoria, hotels, and rooming houses multiplied. They competed with each other -- and with others in other towns -- with publicity about clinical facilities, living comforts, meals, etc. They, too, advertised throughout the country. Much of the publicity about the sanatoria really advertised the exceptional treatments invented by their doctors.

National health insurance had always been designed to provide third party payment of some of the costs at spas. Treatment for chronic diseases had always been covered, in both hospital charges and in the fee schedules for doctors. The sanatoria were recognized in contracts with sick funds as special hospitals for care of certain chronic diseases and for convalescence after treatment in acute hospitals. Senatoria had much political support from their towns, and many were recognized in the hospital plans issued by provincial governments during the 1970's. When benefits and the premium structure for national health insurance were redesigned in 1970, employers were liable to pay the workers' normal wages in full for the first six weeks of disability. (This arrangement replaced cash benefits paid by sick funds from premiums paid by employers. The continuation of the worker on the employer's payroll was supposed to tighten control over malingering.)

Competition among health insurance carriers has provided much of the money for the spas. In order to attract and keep members, each sick fund with extra cash is willing to make some contribution to spa treatment for subscribers. The person goes to his primary care

physician and gets a referral statement diagnosing his condition and recommending care at a sanatorium. Since the physicians compete to keep their regular patients, they are often permissive, judging that someone is "run-down" and "needs a cure." The patient then gets approval from his local sick fund before going off to the sanatorium. If the patient has a chronic disability (such as arthritis or asthma) or is being referred to convalesce after a spell in an acute hospital, the sick fund may agree to pay all or most of the sanatorium costs. It must pay all the physicians' charges consistent with the official fee schedule. Competitive pressures persuade the sick funds to agree to partial payments for the "exhausted" patient. The Ersatzkassen have more income and lower morbidity than the RVO-Kassen and offer more spa benefits in order to attract members, so the RVO-Kassen must go along too, within their resources. Employers' obligations provide the greatest windfall: the doctors' referral requires the employer to pay the person's wages in full up to six weeks per year, and the time is not deducted from paid vacations.

The spas constitute a substantial fraction of German health spending, but it is difficult to estimate the amount. Some of their costs are covered by direct third-party payments by sick funds but most are not. Some patients who appear to pay out-of-pocket are reimbursed in part by their sick funds and private insurance companies; most seem to benefit from the employers' wage payments. The spas' economic importance has become very great and is growing. Sanatoria (Kur-Krankenhäuser) now constitute over one-fifth of all Germany's hospitals, with over one-tenth of all the beds, and other establishments in the spas also provide housing and treatments. During 1978, the sanatoria had 6.7 per cent of all hospital admissions and 10.0% of all patient-days.<sup>11</sup> Maxwell estimated that 5 per cent of all German health care costs went into spa treatment in 1975, but he defined medical expense conservatively and did not count the wage payments by employers or the many expenditures in the resort towns only indirectly related to health.<sup>12</sup> Several hundred thousand persons earn their livings in the towns surrounding the spas. The third-party payments to the sanatoria and to the customers are essential "seed money" in the

massive economy of the spas -- the third-party payments had not been available to the prewar customers -- but most of the expenditure is personal.

The employers' liability for disability pay provides a lesson about the need to think through the design of any payment system. The employer was thought to become the watchdog over abuse, since he would be paying for a worker who needs rehabilitation. Such a restraint may operate in a small business, where the employer's own money is at stake, and where the absence of a worker reduces production. But in many cases, the "employer" is an "it" and not a "he": it is a corporation, and the managers are workers too. The managers go along with paying trips to the spas, since they use the same benefits as the workers, at their higher pay scales. (Likewise, a consensus in favor of employer-paid health insurance exists within American corporations, obstructing the changes proposed by conservative critics. Managers are the chief gainers of the American corporation's fringe benefits.)

#### LESSONS FOR THE UNITED STATES

##### 1. Markets and competition in general:

- (a) A competitive economic market is not an original state of nature. It is a set of rules. Its processes and outcomes depend on whose rules are used. The recent American literature about markets and competition in health is a set of recommendations about how the world should be reshaped, and they vary with the author.
- (b) A competitive economic market cannot be made completely "private" in health or in any other sector. Government always plays a central role in defining and enforcing the rules, in defining and protecting property rights. In every country in past and present, governments play some sort of market role in providing facilities and in spending for services. This role has become much bigger lately everywhere. The policy problem is not to create an ideal "private" market but to work out satisfactory relations between public and private institutions.

- (c) Different forms of competition can be found in health services within each country. There is no single thing called "the market" in health.
  - (d) Competition can increase the total costs for the aggregate of services, instead of restraining costs:
    - (1) Instead of struggling to increase shares of a finite market, the competitors may arouse consumers' tastes, so they buy more, causing expansion of the entire industry.
    - (2) Each competitor may add a sales force. Competition for the best salesmen increases their charges.
2. Insurance:
- (a) Most (not all) people seem to want health insurance with generous benefits, even if they must personally pay a lot. Most (not all) seem willing to pay for first-dollar coverage.
  - (b) In a completely voluntary system, many uninsured are not "rational" self-insurers; they are the profligate poor, those who can't save or look ahead, those who can't understand complex finance. A free-market theorist might bid them suffer the consequence, but Western society does not allow it. Health care originated as a humanitarian charity, and the sick are never turned away. Hospitals and governments inevitably are saddled with the problem of finding the money for these people.
  - (c) Much of the pressure for hospital prepayment comes from hospitals and from government, in order to have an orderly solution to the foregoing problem of coverage.
  - (d) Having to pay for expensive insurance is not an incentive to go easy on utilization. Such policyholders may overutilize in order to "get their money's worth."
  - (e) Competition causes insurance packages to become more alike. Customers go to the carriers with better benefits, not lower premiums. Or, they go to carriers with an image they like.
  - (f) Competition can lead to higher costs for the insurance subscriber and for the system:

- (1) More benefits and more paid-in-full arrangements are offered. Carriers earn more overhead and profits from the more expensive lines and are motivated to discontinue the more limited and cheaper policies, since the public seems easily persuaded to overinsure.
- (2) Insurance sales agents have a vested interest in selling the greatest coverage, since their commissions are a large percentage of the premiums.
- (g) In the long run, health insurance is dominated by a few leading carriers or by one.
- (h) Individual bargaining with hospitals and doctors over their charges for each patient weakens the hands of the patients and of the carriers. In particular, carriers want to offer generous benefits while avoiding ripoffs by providers. So, eventually all the carriers form negotiating committees to face the hospitals and doctors. Collective bargaining leads to standardization of their benefits.

3. Hospitals:

- (a) The entire landscape of hospitals in a country never fits a simple image of intense price and service competition among independent units. They constitute a great mixture. Many forms of competition and maneuver go on.
- (b) In every health system, new hospitals are always highly competitive toward the others, in order to capture a share of their market, cover their fixed costs, and justify their existence.
- (c) A payer with very widespread coverage of hospitals (such as a sick fund under NHI or a government Treasury) opposes competition that causes sudden and large shifts in market shares. The payer may be billed both for the higher volume in the winners and for higher unit prices to cover the fixed costs in the loser. Organized payers usually are suspicious of net increases in workload in any catchment areas with stable populations; they suspect the hospital is manufacturing work.

- (d) Hospital managers and service chiefs eventually become reconciled to stable market shares. They are eager neither to gain nor lose work. Reformers have difficulty persuading them to do more work extramurally.
  - (e) Many hospitals are "monopolists" because they are the only establishments in their communities. But they may be feeble monopolies, with low utilization. By some economic criteria, they should not survive. But communities try to keep them through subsidies. What standards can judge whether the community should keep its own establishment or be forced to use a distant one? What standards can judge the mix of patient charges and public subsidies to cover the hospital's costs? What standards can judge the economies to be forced on an "underutilized" community institution?
  - (f) Private hospitals are often eager to compete with the established public and nonprofit establishments for patients. The outcome is not "natural" and "inevitable." Sometimes the rules about insurance payment and level of facilities are in their favor, sometimes the reverse.
  - (g) Proprietaries seek a larger share of routine and simple cases, and they let the nonprofits take the long-term and complicated cases.
  - (h) The established nonprofit hospitals compete vigorously for equipment, specialists, and technically advanced programs. The competition is for grants from government.
4. Doctors:
- (a) Competition for scarce jobs and dependence of junior doctors on their superiors produces discipline and hard work in hospitals' medical staffs.
  - (b) In such systems, technical advance becomes an important professional motive of hospital doctors. Their work pace is less frenetic than in a system depending on larger market shares, rapid turnover of patients, and profitable short stays.

5. Delivery system:

- (a) If an unusual delivery innovation is being promoted, it must be protected by incentives and restrictions, or it will not survive. An HMO can survive under universal health insurance only if its members are prevented from going into the general market at the HMO's expense. They will accept such restrictions only if they receive extra benefits, which make HMO's more rather than less expensive.
- (b) It may be very difficult to maintain for long a health delivery market with many different forms. The patients and doctors will eventually choose one or a few forms.

## FOOTNOTES

1. The American literature about markets and competition in health is being summarized in a publication by Applied Management Sciences Inc., to be released by the National Center for Health Services Research during 1982.
2. A convenient collection of the rates for payroll taxes and premiums for health insurance and other social security benefits in all countries is Social Security Programs throughout the World (Washington: Office of Research and Statistics, Social Security Administration, U.S. Department of Health and Human Services, annual).
3. About 80 per cent of the French population is voluntarily insured by the sociétés mutualistes for the cost-sharing under official NHI. Glaser, Paying the Hospital in France, Ch. II. No-one has counted the numbers of Swiss citizens who have taken the supplementary policies from their carriers in addition to the basic ones, but the total is believed to be very high. Glaser, Paying the Hospital in Switzerland, Ch. II.
4. Glaser, Paying the Hospital in England, p. XI-22.
5. A convenient summary of the American literature about market failure in the doctor-patient relationship due to the patient's dependence on the doctor is David Mechanic, "The Character of the Medical Marketplace and Its Failures in the Delivery of Medical Services" (Madison: Health Economics Research Center, University of Wisconsin, 1974). The same conclusions should hold true in Europe and Canada, and leading examples of the literature (such as Kenneth Arrow's classic article) are often cited there. What seems remarkable from a cross-national perspective is the potential economic power that the American patient fails to use. My impression would have to be checked in comparative research, but I suspect that his economic dependency on the patient in theory motivates some attentiveness by the American doctor. Perhaps the same quantity is elicited exclusively by professional norms in Europe and Canada.

6. For example, Clark C. Havighurst, "The Role of Competition in Cost Containment," in Warren Greenberg (editor), Competition in the Health Sector (Washington: Bureau of Economics, Federal Trade Commission, 1978), p. 366.

7. 1 BvR 216/51, 23 March 1960, published in Entscheidungen des Bundesgerichtshofes in Zivilsachen.

8. Eugene Vayda, "Prepaid Group Practice under Universal Health Insurance in Canada," Medical Care, Volume 15, Number 5 (May 1977), pp. 382-389.

9. Joseph P. Newhouse, The Economics of Medical Care (Reading, Mass.: Addison-Wesley Publishing Company, 1978), pp. 55-61.

10. Basic data in each annual report of the Deutscher Baderverband. An overview of their organization and management is Graf Waldburg-Zeil, "Die Kurklinik -- ein Wirtschaftsunternehmen?," in 10 Jahre P.E.G. (Munich: Privatklinik- Einkaufs- und Betriebsgenossenschaft, 1980), pp. 40-42. A description of life at the prewar spas -- capturing their combination of medication and gaiety -- is S. L. Bensusan, Some German Spas (London: Noel Douglas, 1925).

11. Bundesminister fur Jugend, Familie und Gesundheit, Daten des Gesundheitswesens (Stuttgart: W. Kohlhammer Verlag, 1980), pp. 236 and 243-244.

12. Robert Maxwell, Health and Wealth (Lexington, Mass.: Lexington Books, 1981), p. 137.



## CHAPTER V

### ADMINISTERING MULTIPLE PAYERS

The typical American acute hospital is paid by a number of third parties and individuals.

Always Blue Cross, in substantial number.

Always Medicare, in substantial number, I.e., a local carrier, often Blue Cross, is fiscal intermediary.

Many Medicaid cases, if hospital is urban. Some cases, elsewhere in country.

Some commercial insurance companies arrange to pay the hospital on behalf of the patient, such as Aetna, Prudential, or Mutual of Omaha.

State workmen's compensation agency covers some patients.

Specialized local funds. Some are connected with an employer, trade union, or association. Some are business corporations that self-insure their managers and (occasionally) their employees.

Special insurance programs, such as FEHBP or CHAMPUS.

Individual patients. Some pass the bills on to carriers. Some pay personally, and a few then try to recover cash from an insurer.

These payers are independent of each other and are rivals.

Several have quite different philosophies of hospital finance: Blue Cross was created to help the hospital cover its costs, while the commercial insurance companies originated to sell cash indemnity policies to patients. The commercials compete for market share among themselves and (collectively) with Blue Cross. Blue Cross and the commercials are rivals in trying to get favorable deals with individual hospitals.

The hospitals have preferred that all third-parties share in the pool of costs and charges, according to the proportions of the total used by their patients. The American Hospital Association's Principles

of Payment for Hospital Care during the 1950's and 1960's included the principle of Ratio of Charges to Charges (RCC). But once the precedent has developed that one third party can pay less than others, the lower payers resist standardization. An opportunity for change was lost when the Medicare law was passed, and, instead, differentiation was institutionalized more firmly. Early drafts would have extended Blue Cross costing and charging principles to Medicare, but the Congressional sub-committees feared that the government's accounts would pay too much. The aged required fewer services and longer stays, at daily costs lower than those of the average acute patient covered by Blue Cross. So, while the Medicare law adopted cost-based reimbursement, the definition was more restrictive than Blue Cross. Medicare pays only for the unique costs of Medicare patients, not for a share of the hospital's total costs.<sup>1</sup>

Even if American payers could adopt the identical payment methods, they have had no experience in collaboration. Each wants autonomy. In particular, the Blue Cross Plans do not want to follow the lead of state government Medicaid bureaus.

Even if the payers were disposed to form a common front, American laws forbid many forms of cooperation. Compared to other countries, the United States has stricter laws against restraint on competition in trade. A byproduct of America's singular extension of commercial reasoning into health is the application of antitrust laws to doctors, hospitals, and carriers. No major court case or Federal Trade Commission order has yet been directed at the relations between hospitals and third parties, but earlier opinions concerning doctors, medical associations, and Blue Shield might be extended into hospital finance.<sup>2</sup> So, the hospitals and carriers now look over their shoulders.

#### DIFFICULTIES

Administrative effort for the hospitals. Each American hospital must send bills to many different places, and therefore each patient's bills must be separately generated. In addition, the bills are calculated differently for patients with identical clinical conditions: some

carriers pay charges and others pay costs; cost-reimbursements follow different definitions of costs for the identical clinical conditions.

Once third-parties expected different financial reports from hospitals. The cost-based reimbursers (Medicare and Blue Cross) required different detailed forms, according to their habits and different definitions of costs. Some charge-payers asked for simple statements, to evaluate the fairness of the hospital's request. Now it is common (but not yet universal) for the principal programs in each state to accept the same end-of-the-year expenditure reports, based on Medicare requirements. State regulatory agencies usually require all to agree. But the hospital must still fill out supplements for Blue Cross and (often) for other third parties.\*

Therefore the American hospital must maintain a considerable accounting and clerical apparatus. Because of the simpler methods of calculating bills and collecting money, a European hospital of even 500 beds can get by with a chief financial officer, a deputy, a few bookkeepers, a few secretaries, and a computer. But the accounting and collection office of an American hospital of comparable size needs many more employees. American hospitals had to adopt computerized accounting and billing much earlier than Europe's.

Administrative difficulties for regulators and negotiators.

Modern rate determination depends on peer group comparisons, as Chapter VI will show. Medicare is a nationwide program although administered statewide by its fiscal intermediaries. Medicaid is usually statewide, although county welfare departments perform some administration in big states. Blue Cross Plans are usually statewide, but some are regional. As a result, the hospitals are assigned to differently defined peer groups (for Medicare, Medicaid and Blue Cross) in some states, when averages and outlyers are calculated. Medicaid rates and ceilings are

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\*Uniformity at best can be achieved within states but not among them, a common problem in federal countries. Medicare requires use of one form (HCFA 2552) but agrees to a document that contains all the Medicare requirements but pleases all the other payers in that state. The computer center processing the end-of-the-year expenditure reports sends a tape to HCFA according to the latter's computer format and accounting definitions. In other respects, each state has a different system of reports and computerized data files, to accommodate the other third parties.<sup>3</sup>

usually calculated from statewide data subdivided on various principles. Blue Cross analysis is confined to that region's hospitals, if the Plan is regional. Therefore, Medicare, Medicaid, and Blue Cross norms are often based on different definitions of the universe.

Price discrimination. Since the American hospital does not treat all payers alike, each payer grumbles that it is being charged excessively and unfairly for costs truly incurred by others. Confronted by several payers pledged to pay the "costs" of their respective patients but pledged by laws or customs to pay slightly different definitions of costs, the hospital's accountants must perform the unreal exercise of pretending to partition the costs of the entire organization so that the average costs of each separate category of patients (e.g., Blue Cross and Medicare) can be distinguished. If certain items are refused by the principal payers, the business office tries to load those costs onto the bills of the other patients.<sup>4</sup> Instead of posting standard prices for all to see, the hospital tries to set different prices for each payer, and the hospital tries to keep the calculations secret, to avoid protests. The hospital's books become very complicated, comprehensible only to an insider. (More details will appear in Chapter IX, *infra*.)

Deviousness in charging is encouraged. In order to avoid antagonizing overloaded payers and getting bad publicity, the hospital manager may appear to charge all payers alike. But he identifies those payers obligated to pay costs or charges in full, and he may try to identify services used by their subscribers in exceptional amount. If he uses item-of-service charging, he may then raise charges in those departments. This is most possible in states without intrusive rate regulation. But even when regulation exists, it may aim only at limiting the annual increase in the average daily cost, leaving the directors free to fix any charges on individual services. The director may then concentrate the annual itemized charge increases on the services used heavily by the payers committed to full reimbursement of costs.<sup>5</sup>

Larger payers may persuade -- or pressure -- the hospital into granting discounts. In particular, Blue Cross argues that it saves the hospital money by the administrative convenience of covering so much of

the hospital's billing and by paying directly and quickly. The other carriers complain that Blue Cross is treated with unfair generosity, because of its traditional connections with hospitals. Blue Cross replies that truly free competition produces differential prices: a large bulk purchaser can negotiate favorable rates.

Even a regulatory program supposedly designed for equitable treatment may produce anomalies because the different payers follow different rules. For example, in New York -- as in all other states -- Medicare patients are paid for according to their costs actually incurred, calculated retrospectively; Medicaid and Blue Cross rates are based on prospective rates calculated at the beginning of the year from the last known earlier year's costs plus an inflation factor; but the costs in the entire Medicaid and Blue Cross calculations until 1981 were the average costs of all services for all patients in the hospital including the aged, since those specific insured populations cannot be isolated in the data. But the daily cost for an aged person is really lower than the daily cost for a younger, largely because of less service intensity, less use of ancillary services. The hospital collected a slightly lower-than-average reimbursement for Medicare patients but not a compensating higher-than-average reimbursement for Medicaid and Blue Cross patients, since cost containment policies of New York State limited many Medicaid and Blue Cross calculations to the peer group average. The Hospital Association complained for years that New York hospitals were constantly paid less than their costs by Medicaid and Blue Cross.<sup>6</sup> Finally in 1981, the ancillary charges of hospitals, a principal reason for the shortfalls, were distributed among payers according to approximate usage.

Enacting a policy for controlling the costs of the system as a whole is hindered, because the payers with bargaining advantages use their political influence to keep down their own payments, tacitly encouraging the hospitals to shift the extra costs elsewhere. They may encourage the hospitals to grow, since their subscribers benefit but others pay. For example, the Carter Administration tried to set ceilings on revenue increases of hospitals from all sources. One obstacle was the Committee on Finance of the United States Senate, which opposed total

revenue limits but (in the Talmadge Bill) amended the rules of Medicare and Medicaid payment, so those programs would save money. The Talmadge Bill would have left the hospitals free to overcharge others.<sup>7</sup> The principal constituency among third parties for capping and for state rate regulation has been the commercial insurance companies, since their subscribers are the chief victims of price discrimination.

If one payer reduces its spending, others must increase it in compensation, even if their own coverage and benefits do not change. Other payers using cost reimbursement go up automatically. Charge payers probably will be confronted with higher prices, as the hospital looks for ways of making up lost revenue. For example, when the national government and the states cut Medicaid payments to hospitals during 1982, the liability of Blue Cross automatically increased in states where it used cost reimbursement. The greater the Medicaid cuts, the greater the shift to Blue Cross. In states without regulation, the shifts are done by each hospital's finance officer according to its own methods. In New York State, the Fiscal Policy Committee of the State Hospital Review and Planning Council had to revise the payment formulae to cushion what otherwise would have been a large sudden increase for Blue Cross in some localities and hospitals, and to avoid a deficit in some hospitals.

Obstacles to creating professional norms. Modern utilization and quality control require pooling all data within each hospital. Then peer comparisons are performed: for example, deviations by a particular doctor can be identified only in the light of all bills within that hospital; exceptional performance by one hospital requires comparisons among many, each with a complete data set of its own bills. But third parties usually refuse to cooperate in maintaining and merging the same financial and clinical records. For example, Blue Cross can analyze utilization within its own file for that hospital, but not in comparison with that hospital's total workload.

#### EVOLUTION ABROAD

Every country once resembled the American situation. The hospital got money wherever it could, charging many third-parties and the

individual patients at varying rates. Just before World War II, every country had thousands of small local funds, organized on a variety of bases. Germany alone had 20,000. Some consisted only of workers of one company, some were sponsored by unions of the Left, some were sponsored by Catholic trade unions, some were sponsored by doctors, many were cooperatives. A few were big, but most had between a few dozen and a few hundred members. The average prewar European hospital therefore faced even more payers than the current American hospital.

The system had great disadvantages. Sick funds widely differed in the average wealth of members, premiums, financial capacities, lists of benefits, and prices for the same benefits. Small sick funds went bankrupt if their members became unemployed. They were badly managed, since few were big enough to employ full-time qualified executives. Competition kept premiums low and benefits underfunded, causing great strains for the hospitals. A few experienced the first hints of the demographic burden that would become serious later in the twentieth century: if a sick fund was small but had existed for a long time, eventually it would have as many retired members (paying no premiums) as employed and premium-paying members, and then its costs would exceed its income.

Federations and mergers. As early as the 1920's and 1930's, sick funds formed regional and national federations. All the funds of the same type (such as Christian, or Socialist, or those based on iron factories, etc.) joined a federation. Then the sick funds could bargain collectively with the medical association over contracts and a fee schedule. They could improve their own management by relying on headquarters, they could standardize methods. Headquarters could lobby with government for laws expanding coverage and setting high compulsory premiums. Members of the regional federation might support an equalization fund, making the list and prices of benefits alike in different parts of the region.

Since World War II, European sick funds have greatly diminished in number and increased in average size. Many small ones in a locality merged; either they joined a large and more solvent one, or they became a new community-wide unit under ideologically "neutral" management.

Costs were an important motive: many were bankrupted by World War II; small ones had an insufficient base to match mounting costs and to cope with unexpected fluctuations in utilization. Mergers were needed to pay for an adequate administrative staff. Even when the local funds remained nominally distinct, often they became very much alike, under the influence of strong leadership from the national federation and because of standards set by the government's national health insurance laws and regulations.

Switzerland has arrived at a similar point but by a different route. Some local sick funds exist as well as national carriers. But Switzerland did not have the slow bottoms-up federation-building in health insurance as in the rest of Europe, although Swiss government and society are extremely localized in other ways. The national government's insurance law of 1911 offered grants to recognized carriers. The ones best able to use the money and administer health insurance throughout all the small markets dotting the country were large nonprofit companies that operated everywhere. They exist today, competing for subscribers and paying for hospital care in each community. Also in each area of Switzerland may be one or two entirely local funds.

In a few countries, the financial base from many payers was insufficient to pay for hospital care. Too many patients were not covered. Insurance subscribers' premiums did not give the hospitals enough revenue for their costs. Therefore, government took over funding: each hospital faced one payer, viz., the Ministry of Health. Examples are Great Britain and Canada. But they are exceptions.

The standardized daily charge. An important force for cooperation among the third parties was the hospital itself. It wanted guaranteed reimbursement of its costs, and a mosaic of different formulae produced inadequate and unpredictable results. European hospitals during the nineteenth century calculated an average daily charge by simple arithmetic: the total expected operating costs were divided by the total expected patient days, and each patient or his third party was expected to pay the charge for each day of hospitalization. Deficits occurred because of miscalculations and bad debts, and the hospitals' owners continued to look for extra funds, but the third party payments steadily covered more of the total operating costs.

The simple method billed every third party and every patient alike, supplemented by only a few fees for individual treatment. The hospital did not care whether some were paid too much in their individual cases, and others too little, so long as it covered its total costs. The third parties had to be persuaded to accept occasional overbilling as an offset to the occasional underbilling. This was possible only when they agreed to join together, with the individual bills spread across all. By the end of the year, each third party had paid the hospital's total operating costs in proportion to its total patient-days. The sick funds went along because the idea of costing hospital care hardly existed. In effect, the system was a global budget spread across many payers in ratio to utilization, defined by days.

European sick funds could agree on the same unit of payment because of certain features in their history, contrasting with the United States. Principles of division in Europe were non-clinical: depending on the country, European sick funds represented different occupations, or they were sponsored by different religious movements, or they were sponsored by different political parties. In use of the hospital, the memberships of different sick funds were similar, even if not identical. In contrast, American hospital finance -- like England's and Canada's originally -- has evolved categorically. Blue Cross, Medicare, and Medicaid represent different patient populations and refuse to share each others' costs, even if the tradeoffs might even out. Therefore, in American states where rate regulatory programs require submission of prospective or retrospective budgets, either the state agency or Blue Cross runs them through computer programs for cost-center stepdowns, so that the costs of different clinical services and ancillary departments can be isolated. Then separate daily charges are calculated for the principal payers, depending on the average utilization profiles of their subscribers. This differentiation by payer is never done abroad; even though payers sense that they are probably subsidizing each other slightly, they pay the same rates.

## CURRENT METHODS ABROAD WITH MULTIPLE PAYERS

Agreement on standardized rates. The principal charges in all national health insurance schemes abroad are common to all third parties. All doctors in a country collect fees according to a fixed fee schedule with few exceptions.<sup>8</sup> The payments to hospitals are not standardized among all; they are individualized according to the budget of each hospital. But every payer pays that hospital's standard rate with no exceptions.

West Germany is one of the few countries where sick funds pay some providers at different rates. The Erstazkassen offer the physicians slightly higher fees than the RVO-Kassen for the same procedures.<sup>9</sup> But such differences do not extend to hospitals. The Ersatzkassen and RVO-Kassen face the hospitals on the same negotiating committee, cooperate closely in evaluating the hospitals' claims, obtain a single all-inclusive daily charge from the hospital, and pay the same amounts throughout the year. The RVO-Kassen accuse the Ersatzkassen of trying to get better treatment for their members from doctors by paying more, but no such accusations arise in hospital care.

Individual sick funds do not save money by getting lower rates from hospitals; not do they get better treatment from a hospital by offering more money for the same service. But some sick funds are more prosperous than others: their members have higher incomes and therefore pay more premiums; or, those sick funds have a higher ratio of employed to retired persons, a higher ratio of contributors to users. Sick funds do not compete in the rates they pay providers, but they do compete for subscribers in their benefits: the richer sick funds are more tolerant of longer stays in hospitals, pay for more benefits (such as stays in nursing homes and in rehabilitation spas), pay higher disability cash benefits, cover prostheses, and so on. Some compete by charging lower premiums, but this seems to attract fewer subscribers than more generous benefits.

European sick funds do not cover better accommodations -- i.e., private or semi-private rooms -- if they have more net income from their basic coverage. These extra hospital charges must be paid for by the

patient out-of-pocket. Swiss sick funds offer extra policies that cover these services. In other European countries -- such as Germany and The Netherlands -- private insurance companies offer these extra policies, not the official sick funds.

Administrative savings. Standardization of rates makes billing very simple, at great administrative savings for the hospital. If the method is an all-inclusive daily charge, as in The Netherlands, the hospital's computer every few weeks generates lists of all discharged patients covered by each sick fund. Each line is the name of the patient, his identification number, number of days in the hospital, and his total cost. The total for all patients is the bill to be paid by the sick fund: number of patient-days for its subscribers multiplied by the standard daily rate applying to everyone. The sick fund does not get individual bills.

Sick funds in some countries receive individual bills, but they are much simpler than American hospital bills, since many fewer services are itemized. Hospital computers in Germany print out a series of individual bills addressed to each patient's sick fund, with all the information appearing on each line of a Dutch list. The German patient's file must be reviewed individually, because some have elected services that must be billed to him separately (such as private rooms) or that result in a lower daily all-inclusive hospital charge (such as retaining the chief of service privately).

Since every payer accepts the same standard rate calculated from the same cost base, the hospital need calculate only simple end-of-the-year expenditure reports and prospective budgets. It need not calculate separate ones for different payers, as in the United States.

Standardization of rates for all payers not only reduces the administrative overhead for the hospital but simplifies the entire payment system. The sick funds can cooperate in their financial administration. For example, sick funds in several French-speaking cantons of Switzerland have created integrated funds (Centrales d'encaissement) that represent all carriers in handling the hospital's bills. Normally, each hospital would distinguish among its patients according to their sick funds, and it would have to bill each carrier separately. Each

sick fund would pay all the hospitals separately, each by a different rate. Instead, the Centrale gets lump sums from all sick funds in the canton and pays all the hospitals. It can average all the expenditures: it calculates total hospital spending for the past year, divides it by the number of patient-days, and multiplies the figure by the proportion of costs chargeable to each sick fund. Each fund pays the Centrale in installments, adding shortfalls or recapturing overpayments at the end of the year. The Centrale pays the hospital for each patient by the usual method, viz., number of days at that hospital's daily rate. The Centrale's staff therefore relieves the sick funds of all the detailed administration of providing guarantees and payment. Because the hospital deals with only one agency instead of all the sick funds, it has much less work.<sup>10</sup>

A Centrale is useful when a region has several sick funds and several hospitals, each administering work that is really the same. In most of Holland, a Centrale is superfluous, since the region has only one or two sick funds and a very few hospitals. But Amsterdam has three sick funds and many hospitals. The Association of Amsterdam sick funds (the Vereniging Amsterdamse Ziekenfondsen or VAZ) administers all the communications, including the guarantees upon admission, the bills from the hospitals, and the payments. It pays in full, merely by multiplying the number of patient-days for all sick funds over several weeks by the standard daily charge for that hospital. Periodically it gets cash advances from the sick funds. VAZ has fifty employees for this work, fewer than the sick funds and hospitals would have to employ separately. From the financial records, VAZ can also keep utilization statistics for the sick funds and hospitals. A similar office to administer specialists' fee-for-service bills is maintained by the Association of Specialists in Amsterdam (ASV).

Unusual payers. In every country, a few payers are not like others: they do not participate in any negotiations to set the pay rates, and they may pay different charges. This invariably occurs in countries where hospitals are paid by global budgets covered by one source, such as Canada and Great Britain. In neither country is the hospital's income a sum of daily charges but it is one month's share of an annual total.

The hospital's business office is supposed to bill the patient or his third party, if he is covered by a special program, such as workmen's compensation or automobile insurance. The payments are counted in the hospital's revenue along with miscellaneous items, such as employees' payments in the cafeteria, employees' rental of parking space, rent from real estate owned by the hospital, and so on. All this revenue is subtracted from the hospital's gross operating costs. It is the net expected operating cost which is then divided by expected patient-days to produce the daily rate; or, it is the net operating cost which forms the global budget paid in monthly installments by the public authority in a few countries.

Since the hospital's finance office is guaranteed its costs, a problem is to motivate it to take the trouble to bill the special payers. Although hospital managers in some countries (such as Britain and Germany) are encouraged to collect private room fees by keeping part of them in a special fund not deducted from net operating costs, such incentives usually are not offered for collecting special payments for basic care.

#### LESSONS FOR THE UNITED STATES

Offering the hospital different rates of pay for the identical service is pointless from the perspective of the system as a whole. Doctors and hospital staff members are supposed to be bound by professional norms, giving optimum care to the patient regardless of payment. In countries with sliding scales -- for example, where a doctor can collect higher private fees from some patients as well as the official sick fund rates for others -- doctors commonly deny that they give "better" care to the more remunerative patients. Differential payments to a doctor who actually delivers the care may pay off by motivating him to give more time. But differential payments to a hospital for otherwise identical patients probably have little clinical effect, since the persons handling the bills are remote from the persons giving the care, and the clinicians are unaware of the financial nuances.

Hospital managers do not like differentiation among payers, because of the uncertainty in results and because of the administrative burdens. Their goal is full and predictable reimbursement of their costs as they define the costs. Therefore, they prefer pooling all payers and charging each a full share of the budget.

Differentiating among payers is favored by those payers who think they can get away with less, causing the hospital to overcharge others.

If hospital prices are standardized for all, third-parties can still compete in their offerings to subscribers. Instead of paying higher hospital charges for the same services, they use extra funds to offer additional benefits. They can still compete for the favor of hospitals by offering prompter payment and other administrative help.

Standardizing payment among all payers relieves the hospital of much billing. The reporting of costs and prospective budgets can be uniform for all payers. Administrators are less tempted to juggle the books, since costs are aggregated, and assignments to payers follow simple rules, like share of total patient-days. All third parties can save administrative costs by creating a common agency to administer bills for all basic services.

Rate regulators and negotiators are helped by standardization. All data can be pooled and manipulated by computers when defining and comparing peer groups.

## FOOTNOTES

1. Irwin Wolkstein, "The Legislative History of Hospital Cost Reimbursement," in Reimbursement Incentives for Hospital and Medical Care (Washington: Office of Research and Statistics, Social Security Administration, U.S. Department of Health, Education, and Welfare, 1968), pp. 1-15; and Judith M. Feder, Medicare: The Politics of Federal Hospital Insurance (Lexington: Lexington Books, 1977), Ch. 4.

2. Clark C. Havighurst, "Antitrust Enforcement in the Medical Services Industry: What Does It All Mean?," Health and Society, Volume 58, Number 1 (1980), pp. 112-113; and Havighurst, "The Role of Competition in Cost Containment," in Warren Greenberg (editor), Competition in the Health Care Sector (Washington: Bureau of Economics, Federal Trade Commission, 1978). See also the militant language of the FTC in In re American Medical Association, 94 F.T.C. 701 (1978) and in the briefs of the F.T.C. and its amici curiae in the appeal before the Supreme Court, American Medical Association et al. v. Federal Trade Commission (Supreme Court of the United States, October Term 1981, Case No. 80-1690).

3. The great complexity in creating uniform reporting within and among states, and the great burdens for the hospital both under the existing arrangements and under improvements necessitated by cost containment programs are described in Katherine G. Bauer, Improving the Information for Hospital Rate Setting (Boston: Harvard University Center for Community Health and Medical Care, 1976), esp. pp. 30 and 133-163; and Diane Rowland, The Transition to Uniform Accounting and Reporting for Hospitals: Some Perspectives from Participants (Boston: Harvard University Center for Community Health and Medical Care, 1976).

4. For example, the Massachusetts Hospital Association has documented the costs not paid by Medicare and Blue Cross (because of their contractual allowances) and not paid by Medicaid (because the state got an HEW waiver to pay per diem charges that are even lower than Medicare costs). The reports show the extra loading on the few (15 per cent of all patients) self-payers. Impact (Burlington, Mass.: Massachusetts Hospital Association, 1978 and 1980).

5. Examples from Ohio and Maryland in Fred J. Hellinger, "Hospital Charges and Medicare Reimbursement," Inquiry, Volume XII, Number 4 (December 1975), pp. 313-319; and Graham Atkinson and Jack Cook, "Regulation: Incentives rather than Command and Control," paper at a conference of the American Enterprise Institute, 1980, pp. 9-15.

6. Seventh Annual Fiscal Pressures Survey 1977 (Albany: Hospital Association of New York State, 1978), p. 8; and Hirsch S. Ruchlin et al., "Cost of Hospital Care and Third Party Reimbursement," New York State Journal of Medicine, March 1981, pp. 411-415. How different calculating methods assign costs to payers in different ways is described in Howard J. Berman and Lewis E. Weeks, The Financial Management of Hospitals (Ann Arbor: Health Administration Press, Fourth edition, 1979), pp. 180-182.

7. The differences between the Carter and Talmadge Bills and the maneuvers between the rival sides are described in David S. Abernethy and David A. Pearson, Regulating Hospital Costs (Ann Arbor: AUPHA Press), pp. 125-127 and 169-181.

8. I have described fee schedules under national health insurance in Glaser, Paying the Doctor (Baltimore: The Johns Hopkins Press, 1970), Chs. VII and VIII.

9. The separate negotiations with the medical associations by the rival sick funds are described in Glaser, Health Insurance Bargaining (New York: Gardner Press and John Wiley, 1978), Ch. VI.

10. Glaser, Paying the Hospital in Switzerland, pp. IX-6 and IX-7.

## CHAPTER VI

### REGULATION

Hospital pay is decided by the following methods abroad, as I said in Chapter II, pp. 7-8.

Hospital sets its own charges

Negotiation with third parties

Screening by an agency accepted by the negotiators

Regulation by a public agency

Single payer grants an amount that it sets.

This chapter will describe how rate regulation works abroad. It includes some descriptions of the screening agency in Holland, which operates much like a public regulatory body. The next two chapters describe negotiations and grants.

Since much of the debate about hospital rate regulation in the United States deals with the nature and merits of all sorts of regulation, this chapter begins at that point. Then, a discussion of the disparate types of regulation that bear upon the hospital, both in the United States and in Europe. Then, a comparison of how hospital pay is regulated in the United States and abroad.

This chapter deals only with the general organizational features of rate regulation in the United States and Europe. Later chapters discuss methods in detail.

### CURRENT CONTROVERSY IN THE UNITED STATES

At present, the United States is passing through one of its recurrent periods of disenchantment with "regulation." On close inspection, "regulation" is not a finite set of activities and may be shorthand for "government" generally, so that Americans may really be hoping that government will disappear and that their frustrated dreams finally will be realized through the "magic of the marketplace."<sup>1</sup>

Each period of complaint about regulation produces exposés of "regulatory capture," viz., how the interest groups supposedly being curbed to satisfy the public interest gained undue influence with the regulatory agency, and how the rascals became stronger and richer forever by misusing the regulatory machinery.<sup>2</sup> The critique is overdrawn in that it focuses on a few agencies and programs alone; actually it is common for every government to receive predominant influences from the interest groups who have the most at stake; all parts of American government and not the implementation agencies alone respond to the interest groups who invest time and effort in communicating with and electing them. Much of the complaint over a regulatory agency is really protest over the responsibilities given it by the legislature or confusion over the belated discovery that the legislature could not agree on a policy and handed policy creation over to the regulators.<sup>3</sup>

A more subtle approach is to examine each industry that confronts government rules and implementing officials. The problem of regulation is to obtain compliance from all producers. The regulators do not merely proclaim their rules, but a complex social interaction occurs, as it does in all relationships between government and the private sector. No two industries have identical experiences, and the regulatory relationship changes over time. Regulation consists of constant negotiation between the regulators and the many providers, and compliance is always a compromise. An essential element is the regulators' search for information and understanding; if they learn a great deal, they can drive harder bargains with deviants and can coach the bulk of the industry to work in compliance.<sup>4</sup> How to design regulation and how to remedy existing regulatory weaknesses depend on the industry and the dominant problems.<sup>5</sup>

#### REGULATION OF HEALTH SERVICES IN THE UNITED STATES

Past American controversies over the nature and legitimacy of regulation usually exempted health services and hospitals, since these activities were left to the private sector. Hospitals were managed

and financed privately, the national government had nothing to do with them, and state hospital laws were few and permissive. Hospitals did only good and did no wrong, their managers and the doctors knew their esoteric affairs best, and public officials concentrated on other fields. However, when much government money poured into hospital construction, operating costs, and education after 1950; the grants and entitlement programs had program conditions; and exposés of "fraud and abuse" led to many rules and sanctions. The consumer and environmental movements obtained much new legislation about safety and pollution. By the 1970's, both the national and state governments were active in health, providers and taxpayers complained, and the new generation of medical economists included health in the new flurry of accusations about expensive bureaucracy and regulatory capture. The critics included health in the new across-the-board proposals to repeal most regulations and let "market forces" effectuate beneficial self-regulation.<sup>6</sup>

Sweeping generalizations about regulation-in-general do not fit hospitals, because they are involved in several different situations, in the United States as well as in every other country. Each situation raises a different type of issue, and a different set of regulators.

First, the American forms of hospital regulation. On a later page, how these situations are handled abroad:<sup>\*</sup>

1. Construction of new buildings, acquisition of very expensive equipment. Problem is to protect public funds from waste, since government programs will be billed for much of the operating costs. Planning machinery creates a system of hospital services with a division of labor; new construction and expensive new equipment are screened by advisory committees and approved by state agencies.
2. Regulation of the rates of insurance carriers. Problems are to protect the subscribers from (a) overcharging, waste, and profiteering by the carriers and (b) insolvency of the funds. Subscribers are not organized and cannot be protected otherwise, except by the worse risk of dropping all insurance. State insurance commissions review the carriers' rate increase applications and their accounts.

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\*I discuss only those regulations germane to hospitals. Others exist in health and have become controversial, such as regulation of individuals' rights to practice the health professions.

3. Regulation of the rates of hospitals. Problem is to protect consumers, both the self-payers and those organized in sick funds. Agencies of state governments or public commissions examine hospitals' budgets, apply each class of payers' rules on allowable costs, and recommend the rates for those payers.
4. Safety. The problems are to protect the unorganized population, which lacks knowledge of dangers and therefore which cannot protect itself:
  - (a) Safety of the hospital building. Problem is to protect helpless patients. Inspectors from local and state governments check the facilities. Protection has evolved to minimum standards for personnel, minimum comforts for patients, quality of service.
  - (b) Safety of products used by hospitals and by ambulatory patients. Problem is to protect consumers because they are not organized, they are not knowledgeable about medical products, the manufacturers keep essential information secret (such as adverse reactions), and the companies try to mislead the public with lavish advertising. An agency of the national government -- the Food and Drug Administration -- has tested proposed drugs and some other materials for some time, refused to license those its testers found dangerous, has refused to license others until sufficient information was filed by the producers, and at times has tried to block drugs that were technically harmless but ineffective.
  - (c) Safety of all other products sold to the public, protection of the environment. These efforts are not integral parts of hospital regulation, and I shall not dwell on them. They are designed to prevent mass afflictions that would burden the hospital, particularly cancers. The efforts result from a great expansion of the public health movement during the 1960's and coalescence with a new environmental protection movement. Two new regulatory agencies of the national government were created, inspired by the FDA, viz., the Consumer Product Safety Commission (CPSC) and the Environmental Protection Agency (EPA).

The foregoing American hospital regulatory efforts encounter several problems, due to their missions or the constellation of social forces:

1. Construction and purchases. Motivations to build and buy are strong and the opportunities great. Hospitals seem profitable -- provided they are not burdened by poor people and chronically ill -- since prospective reimbursement restraints are weak, many patients have carriers obligated to reimburse costs, and the hospital has great freedom in charging those not covered by third-party agreements. Cost reimbursement methods obligate carriers to pay high unit prices for underused facilities. American hospital owners cannot easily be restrained in advance, since they can borrow in the private capital market and include the borrowing costs in the prospective budget underlying patient charges.

The regulatory problem is to protect the payers, and particularly government treasuries. But government is remarkably weak in defending its money. Facilities planning laws of the national government are weak, frequently amended, and periodically repealed. State planners' powers are restrained by the working of their laws, by providers' law suits, and by political pressures. Ordinary citizens are not exercised by high hospital costs and can easily be mobilized by hospital managers to protest against planning restraints. In other words, when he is organized into a group, the consumer/taxpayer often lines up against regulation. Therefore, health facilities planning in the United States becomes a system of negotiation and distribution among established providers, easily defied by rebels and entrepreneurs.

2. Insurance rate regulation can have unexpected cost-increasing results at the expense of the unorganized subscribers, since the laws obligate regulators to make sure that the carriers can reconcile their premiums and costs. Therefore, commissioners are ready to increase premiums if payouts rise and insolvency looms. For the usual insurance policies paying fixed cash sums, the carriers are allowed great discretion in fixing their benefits and their premiums. The regulators are concerned only that the carriers are

not exploiting the subscribers by offering low benefits for that structure of premiums and risks; and that the carriers are not endangering the beneficiaries by not accumulating a sufficient reserve for the probable payouts. State insurance commissioners monitor the health insurance policies offering indemnities only from this perspective of consumer protection. State insurance regulation is one of the oldest forms of government intervention in the United States, antedating the national ICC by several decades.

The prepayment policies promising to pay the patient's costs in full or with minimum cost-sharing differ from traditional insurance, since the carrier loses control over its commitment and hands it to the hospital. Blue Cross was created by the hospitals to find much of the money needed to cover its costs; for many years it did not try to drive hard bargains with individual hospitals prospectively and did not refuse to pay high bills. The commitment of Blue Cross steadily rose, the state insurance commissioners had no authority over hospitals, and they were bound to allow Blue Cross to increase its premiums.

State Blue Cross Plans began to bargain more actively with the hospital during the 1970's. Several state insurance commissioners refused to grant higher premiums unless Blue Cross demonstrated efforts to resist the claims of the hospitals. The vigorous commissioner for Pennsylvania, Herbert Denenberg, prescribed the topics that Blue Cross and the hospitals should cover in their contracts, including prospective review of the hospital's budget by Blue Cross, reduction of excessive budgets, controls over the numbers of hospital employees, standing machinery to review utilization, etc. Such machinery has become customary in the Blue Cross agreements in Pennsylvania.\*

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\*State insurance agencies always have been frustrated over their lack of direct leverage over the sources of health insurance costs. They can only tell the carriers to be stricter. The only direct confrontation arises when an HMO applies for a rate increase. Then the hearing officers can question the provider's administrator and chief medical officer directly about current and projected facilities, utilization, and so on. To deal with the carriers and the HMO's, the state insurance agencies now must employ specialists in health costs.

3. Rate regulation of hospitals. Around 1970, no-one bargained stringently with hospitals over their charges, despite the fact that consumers were organized into carriers. Government might have been a bargainer, but the Medicare and Medicaid statutes were written under the influence of Blue Cross and the hospitals, committed governments to pay the hospitals' costs retrospectively, and gave the administration of Medicare to Blue Cross. The private insurance companies did not bargain with hospitals but paid fixed indemnities to patients.

During the early 1970's, several state governments intervened in this vacuum by creating regulatory commissions. One motive was to control their own Medicaid expenditures. Another was to relieve the pressures from the carriers upon the state insurance commissioners. Some important political forces favored the state regulations, particularly the insurance companies: by limiting the hospitals' charges, regulation restricted the out-of-pockets by holders of indemnity policies; it protected the fledgling cost reimbursement programs projected by a few companies; regulators would standardize discounts and allowable costs, improving the companies' competitive position in relation to Blue Cross. The national government soon endorsed adoption of hospital rate regulation by all states, to control its own Medicare and Medicaid expenditures. Later during the 1970's, the Senate Committee on Finance and the Carter Administration groped for formulae that would automatically restrain increases in hospital revenue and expenditure without creating a national regulatory commission.

Experiences have varied among the states. Survival and success of the regulatory programs depend on:

- (a) Political support by the state government. The greater its Medicaid load, the greater the support. But support can arise from other sources too, such as the need by insurance companies to limit payouts.
- (b) Tolerance by the hospitals. They will accept regulation if they helped shape the program and fear greater controls. Once serious, these fears may now be subsiding.

(c) Political skill by the leadership of the regulatory agency.

Several commissions (such as Maryland and Washington) have been resourceful jugglers, acting as both controllers and management consultants, restraining costs but also gaining the cooperation of the hospitals, perhaps gaining enough favor among carriers and hospitals to survive the nation-wide backlash against regulation of the early 1980's. Others (such as Colorado) could not accomplish enough and gain supporters in conservative environments, and hospitals successfully pressed for their abolition. Regulatory programs in several states with unusually high costs (Massachusetts and New York) fought a running battle with the hospitals, but the state governments kept them in order to restrain Medicaid costs and in order to force closings and mergers. In summary, the experiences in these five states have been:

|               | <u>State govt.<br/>support</u> | <u>Tolerance<br/>by hospitals</u> | <u>Political strength<br/>of regulators<br/>with hospitals</u> |
|---------------|--------------------------------|-----------------------------------|--|
| Maryland      | +                              | +                                 | +  |
| Washington    | +                              | +                                 | +  |
| Colorado      | -                              | -                                 | -  |
| Massachusetts | +                              | -                                 | -  |
| New York      | +                              | -                                 | -  |

4. Safety problems are a classic regulatory situation, wherein an unorganized and helpless population needs the protection of its elected representatives and of experts against possible dangers from venal rascals.

(a) Regulation of building safety and of staffing adequacy is accepted widely with little controversy, except for occasional complaints that standards should be higher. The subject resembles fire laws: a very widespread consensus supports this regulation, including the leadership of the hospital industry. This form of regulation levels the lesser hospital up to the standards of the better ones. Occasional accidents and scandalous revelations in the mass media strengthen

enforcement and raise requirements. Evaders are unpopular. (The principal opponents of safety and staffing regulation in health are a slightly different group, the proprietary nursing homes.)

- (b) Regulation of drugs and food pits government and a constituency of reform-minded publicists against important business firms who will lose money.<sup>7</sup> This regulation is nearly a century old, has survived many struggles, and has become permanent. During its first decades, the regulatory agencies were under constant attack in the courts and Congress. Both the food and drug companies have learned to prosper within the boundaries, the drug companies through ingenuity in producing many new products and through their ability to sell unlicensed products in less regulated foreign markets. The regulatory agency has supporters who have learned to arouse the mass media and agitate the Congress with hair-raising exposés. Evidence of the acceptance of pure food and drug regulation came during the 1980's: while the Reagan Administration tried to phase out regulation of product safety and environmental protection, its initial changes in FDA were designed only to accelerate approvals.\*
- (c) Products and environment. The newest regulatory programs -- resulting from the most recent displays of the American tradition of "muck-raking" attacks on rascals -- product safety and environmental regulation -- are now experiencing the same political heat that pure food and drug regulation had to survive earlier in the century. The requested companies face severe losses from conscientious enforcement and at present seek exemption from specific regulations and (better

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\*Eventually the Administration will have to resolve a policy issue inherent in regulation of safety that grants advance approvals, viz., whether a licensing threshold below no-risk should be adopted, where to draw the line, how to balance risks and benefits.

yet) crippling or repeal of the agencies.\* Presidents earlier in the century protected the food and drug regulators, but much of the Reagan Administration's political constituency comes from industries regulated over product safety and environmental pollution. Since the problems are interstate -- commerce, water flows, and air movements -- individual state governments cannot efficiently regulate the subject, even if they could muster the political will. Controlling uncooperative manufacturing industries is more difficult politically than controlling hospitals.<sup>9</sup>

#### REGULATION OF HEALTH SERVICES ABROAD

All the foregoing problems confront every country. The first three are handled somewhat differently in Europe and Canada, avoiding some of the pitfalls of governmental regulation. The following paragraphs are brief, and later sections of this monograph will present more detail.

1. Construction and expensive equipment. Except in Great Britain, hospitals are still owned by voluntary associations and by local governments. Early in the twentieth century, they obtained construction money from owners and charitable donors. Equipment had not yet become complicated and expensive; it too was bought by owners and donors. By mid-century, construction and equipment costs had risen much faster than the revenue from endowments and donations, better hospital care became a policy of governments, and most national governments provided investment grants from general revenue.

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\*The new regulation has touched off conservative complaints about intrusions by government and very high compliance costs. Research about actual experiences shows mixed results: intrusions and costs are higher at some times than others, higher for some companies than for others, greater in some fields of regulation than others. The new forms of regulation are too recent and must deal with too many complexities to have become potent.

By the 1970's, governments became the principal (often the exclusive) sources of money for new hospital buildings, major renovations, and expensive equipment. In federal systems, the money usually has come from provincial governments, often in shared-cost programs with national governments. Government grants coexist with diverse methods of financing operating costs, viz., full Treasury financing of care (Great Britain and Canada), partial government financing of care (Switzerland), charges negotiated with and paid by sick funds (Germany). French public hospitals do not receive outright grants but borrow at low interest from capital funds of the national government and sick funds; the rate regulators guarantee them enough money to repay. The American Hill-Burton program is unusual in that it was phased out and did not evolve into complete public financing of hospital investment.

If governments grant the money, a regulatory agency is not needed to review proposals, such as the American planning agencies. One of the few countries where hospitals still seek their own money for investments and find it in the private sector is The Netherlands. It never had a program of general government investment grants. Once its hospitals got such money from owners (voluntary associations and local governments) and later they were able to borrow on the private capital market. This is possible because -- even more generously than in the United States -- amortization and depreciation are allowable costs in charges for patient care. As in America, the hospitals have therefore been very free in initiating new construction, major modernizations, new equipment, and new programs. As in the United States, the government has created machinery to write plans and to screen individual hospitals' proposals, but the levers falter because the commissions cannot create a consensus behind definite policies, the hospitals have the advantage of initiative and private financing, and the government's authority to reject proposals is weak both in law and in political will.

2. Insurance premiums. Setting the sick funds' rates is more closely coordinated with setting the sick funds' costs than in the United

States. By the late 1970's, the rate regulators and negotiators who were deciding hospital payment in several countries were supplied with data about the likely trends in each country's personal income and the revenue of the funds. These officials were advised to try to keep the sick funds within the financial capacities of current premiums. The goal was to prevent hospital costs from absorbing more of the sick funds' revenue and more of the countries' personal income. Detailed guidelines are sent to regulators and negotiators by the Ministries responsible for social security. If rises in payroll taxes are needed, the Ministries must take the heat by issuing decrees or by asking Parliament to amend the tax laws.

West German sick funds negotiate the daily charges with the hospitals. They also have the authority to set their own subscription rates, subject to the oversight of the provincial and national governments. A reason they are strict bargainers is their determination to avoid increasing premiums.

3. Regulation of hospital charges. Almost all statutes abroad state that the hospitals must be guaranteed the costs of giving appropriate care to patients. The regulatory process by civil servants (as in France) or by a commission (as in Holland) is intended to make sure that the hospital does not claim higher rates than are needed for proper care. In those countries where the provincial governments pay global budgets or pay daily charges designed to cover budgets -- such as Canada and Switzerland -- the statute also requires governments to cover the costs of appropriate care, and the official investigation is designed to prevent overpayment. "Regulatory capture" does not occur, in the American sense of seduction of agency personnel by the hospital industry, since the civil servants gain nothing from the industry. It is the law that guarantees full financing of the hospital. Civil servants are not seduced by a "revolving door" into the hospital industry, since the civil service is a better career. If officials give the benefit of doubts to the hospitals' submission, it is because they lack the time and expertise to understand the hospitals' accounts as well as

the establishments' own financial staffs. Or, as in Holland and Canada, the regulators and grantors lack statutory authority to compel production of the hospitals' files. But these regulators can never become industry-oriented to the same extent (for example) as regulators in American transportation and communication, since they must also deal with powerful organizations of consumers, viz., the sick funds.

A negotiating system like Germany's produces a struggle between interests and policies. The German national government's hospital finance law requires that hospital reimbursement covers the hospital's appropriate costs. The national government's social security law requires that the financial solvency of the sick funds be protected. An issue therefore is who arbitrates deadlocks, and by what criteria. At present, the decision is made by the Ministry of Health in each provincial government. But the sick funds think government is too solicitous of the financial strength of the hospitals -- since government owns some hospitals -- and not concerned enough about the finances of the sick funds. So, the sick funds now favor amending the law, to assign arbitration to a committee (a schiedsamt) representing the sick funds and hospitals equally.

#### 4. Safety

- (a) Buildings and personnel. Many countries have had safety regulations and inspections by government since the nineteenth century, and these regulations have long ceased to be controversial. The regulatory task has been eased by the cooperation of the hospital owners: the churches and voluntary associations have not tried to skimp on facilities and pocket any profits.
- (b) Drugs and medical products. Regulators exist in Ministries of Health, but their approach differs from the Americans'. Unless something is manifestly dangerous, it is allowed on the market, but it is pulled off quickly if it seems to create new damage. FDA licenses a drug in advance if it has passed safety tests. In this area, the economic market is freer

outside the United States.\* The problem for developing countries is the lack of controls over drugs found to have been dangerous in Europe and North America.

- (c) Consumer products and environmental protection. The consumer and environmental movements spread to continental Europe from their origins in Scandinavia and North America, and therefore the policies and administrative machinery are new. The work load is lower abroad; so many products are created in the gigantic American market and the United States has so much industry (and polluters) that American regulators are swamped. Policy creation and implementation are simpler abroad: regulators act with less evidence and with less documentation, since they are less likely to face lawsuits designed to emasculate their powers; disputes are resolved in administrative hearings and administrative courts, requiring less time and simpler procedures than in the general American courts; foreign regulators can act until courts or legislatures reverse them, while American regulators are often blocked for long periods by injunctions. A hazard during the early years of every American regulatory program -- in hospital affairs as in all other sectors -- is that the litigant is often a stalking horse for the entire industry, searching for judges to declare the entire regulatory program unconstitutional or at least in excess of its proper powers.

The administration of hospital regulation differs between the United States and Europe, resulting in higher overhead costs for the United States:

1. Many different government agencies regulate hospitals in some fashion in the United States: national, state, and local; several agencies within each level. In addition, the hospital industry

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\*Lessons from abroad were cited by the Reagan Administration in changing FDA regulations, to accelerate screening approvals of new drugs. Almost all new drugs were said to have been on European markets before they were available in the United States, and more patents were being obtained by foreigners.<sup>10</sup>

itself regulates its members in great detail, through JCAH accreditation and state hospital associations. Hospitals must also satisfy conditions of Blue Cross contracts. The result is a very large number of forms with different styles not susceptible to a standardized mechanized response and with much duplication of information.<sup>11</sup> In Europe and Canada, oversight of a hospital is concentrated in a minimum number of agencies. Often they accept responses to each other's questionnaires. (For example, the hospital's response to the Swiss national hospital association's annual survey are also used by cantonal Ministries and sick funds. In the few countries where each report is confidential, such as Holland, duplication and higher administrative cost result.)

2. The extensive self-regulation by the hospital industry itself through JCAH, state hospital associations, and professional associations is almost unique to the United States. (The only other countries with voluntary accreditation are two strongly influenced by the United States, viz., Canada and Australia.) Exactly how to fit together public regulation and the industry's own self-regulation is puzzling, particularly if JCAH has accredited a hospital found wanting in spot checks by the state government and by Medicare. The latter is supposed to pay for care only in hospitals of adequate quality; is the condition met by accepting JCAH, or does it require a complete inspection staff of civil servants, or can HCFA make JCAH a more effective enforcer of the government's standards?<sup>12</sup>
3. Suspicions about underserving and fraud are common in the United States, repeatedly fed by exposés of nursing homes in the media, by legislative committees, and by grand juries. Much American hospital regulation is devoted to quality and safety and requires detailed reporting. Deliberate underserving and fraud are less common in Canada and Europe because of the greater role of religious groups and religious individuals in hospital management, the closer financial monitoring by government and sick funds, the proximity of sick funds protecting their beneficiaries, and the lower amount of petty fraud in those societies generally.

## REGULATING HOSPITAL PRICES IN THE UNITED STATES

Sources of the American style. In other industries in the United States, rate regulation was inspired by muckraking: a particular industry was thought to be full of rascals, the public was being defrauded by services that were unsafe or overpriced, and government was needed to restrain venality and/or to re-establish benign competition. Unlike European socialism, American muck-raking assumed that the remedy was personal and moral, not structural: drastic reorganization of property relations in the industry was neither necessary nor desirable, the government as owner would be captured by new rascals and would be as exploitative as unrestricted private owners, the problem was to warn all owners and managers that they could not get away with fraud and profiteering, the problem was to pressure all owners into acting like "rational" and "moral" competitors and organizational caretakers. (American business and regulatory philosophy derives not from Marx but from theorists of individualistic moral responsibility, such as Hobbes, Smith, and Bentham.) The regulators of abuse and profiteering should be truly independent, viz., a public commission which could not be captured by rascals in the industry or in the political parties. Therefore, the United States has developed in all levels of government a considerable regulatory effort lodged in commissions and autonomous agencies, committed to strengthening private ownership and management.

The benevolent spirit of hospital rate regulation in the United States. It has been easy to initiate determined rate regulation or product safety regulation of railroads, telephones, meat, etc. Otherwise the public would be defrauded and severely overcharged. But hospital rate regulation lacked this determined thrust. The hospital was a savior, not an exploiter. It was a community institution, not a monopolist. It was run by selfless Pillars of the Establishment, not by Robber Barons.

The problem was that prices and use of hospital care were rising faster than the financial capacities of private and public payers, not that hospital care had become an oligopoly controlled by

rascals. Normally in America high prices are challenged by private action: consumers organize and bargain prices down; or, new entrepreneurs try to attract business by offering lower prices. Consumer resistance did occur: Blue Cross Plans in several states created offices to investigate hospitals' financial demands and bargain over rates. Many of these offices were called "commissions" to convince hospitals they were not mere self-interested agencies of Blue Cross, but actually they were not like independent regulatory commissions of government. Their jurisdiction was confined to the hospitals' Blue Cross bills.

New entrants did not come to the rescue by driving down prices. Hospital care seemed not like other markets: the new entrants were more not less expensive, since they were fancier, and the older hospitals emulated their facilities and prices. The principal payers favored government rate regulation, but their motives varied: state governments wanted to control Medicaid costs; the national government was obligated to pay the hospital's "reasonable costs" under the Medicare law and therefore needed investigative machinery to validate the costs; the private insurers belonging to HIAA wanted a general pricing policy that would eliminate the Blue Cross discount and make health insurance more competitive. Lest the national and state governments' need to lid Medicare and Medicaid produce harsh regulatory commissions, several state hospital associations encouraged state legislatures to enact benign laws. Hospital regulatory offices and commissions were created in several state government, without the clear-cut mandate of regulation over other industries. Most hospital laws emerged from mixed lobbying from both the hospital associations and the payers; designed to protect all sides and guarantee the survival of the hospitals in the face of restraint, most laws were long and complicated.

Since their missions differed from those of rate regulators in other fields, hospital rate regulators' calculating methods differed. In many industries, the problem was to ensure a fair rate of return on capital, as if a free market governed. The regulators' calculations -- often elaborate analyses of the economies of the entire regulated industry and of comparable industries -- have devoted much attention

to definition of the capital base and estimating its cost. Further calculations estimate rates of return necessary to achieve public policy goals, such as attracting new capital for replacement and for innovation. Calculating rules were expected to apply equally to stable and rapidly changing situations. Regulators were expected to bring about a fair result, not intrude into management.

But hospital financial regulation required different methods to deal with its different issues. Hospital regulators were concerned with the total expenditure by the individual hospital and by the total industry, while business regulators were not. Hospital regulators often sought to reduce utilization, while private business was encouraged to increase it. Since most hospitals were nonprofits -- particularly in the states with regulation -- the concepts of "fair return on capital" or setting profits sufficient to attract capital did not enter. Regulators were expected to save some hospitals from bankruptcy, not let them collapse. Hospital financial regulation was addressed to price and cost control for an entire industry, but this effort in other sectors was an emergency wartime effort of the national government, not a task of a regulatory commission. Other rate regulators did not second-guess the managers of the industry, but the hospital regulators were soon involved in management decisions.

A motive for adopting regulation in several other industries has been the creation of a "more orderly market." Although not an original motive of the authors and lobbyists of state hospital rate regulation, this idea became a function once it was adopted. The aim in other industries has been order among providers; in hospital payment, regulators came to be a source of order among the multiple payers, who were getting in each other's way. Medicare was guaranteeing past costs, within the restraints of formulae devised in Washington, and it could draw upon unlimited funds from the social security system. Each Blue Cross Plan negotiated bilaterally with each hospital, paid a prospective per diem, and tried to get the best prices for itself. Medicaid was an obligation of state and national government budgets; both tiers had constant problems of predicting the expenditures. Commercial insurers and self-payers had no machinery to influence the

individual hospital's prices and suspected overcharging. The rate regulators created a common front which the payers could not form by themselves. The regulators restrained secret price discrimination by the hospital and the tendency of the hospital's finance office to try to raise everyone's charges up to the levels of the softer touches.

Methods. Rate regulators in the United States do their job as follows:<sup>13</sup>

1. Strong independent commission. Much like independent regulatory agencies in other industries, without the biases of muckraking hostility to the industry and without regulatory capture. E.g., Maryland Health Services Cost Review Commission. Enough authority to cover all payers, even Medicare, and all hospitals. Power to set rates and to levy sanctions for non-compliance. A large staff and respected leadership. Staff sufficient for thorough analysis of hospital rate applications. Use of formulae is supplemented by judgments about needs of individual cases. Due process in hearings.
2. Strict price controls. The regulators are state officials, particularly concerned that the hospitals must keep within the fiscal capacities of their owners (especially the state and local governments) and their payers (especially Medicaid). At various times, Massachusetts<sup>14</sup> and New York. A tumultuous situation, since the hospitals barrage the regulators with appeals through the established procedure, law suits, and complaints in the mass media. The hospitals have many friends in local government and in the state legislature, who ask the regulators to reverse their decisions, who introduce special bills for individual hospitals in the legislature, and who threaten to change the laws underpinning the regulators.
3. Management advice. The regulators are an independent commission, trusted by the hospitals. The law bids them recognize the financial viability of the hospitals as well as the solvency of the payers. The regulators judge that the problem is to help the hospitals become more efficient and to develop a division of labor. Punitive confrontations are avoided, lest the state legislature change the law to weaken the regulators. For example, Maryland and Washington. This approach persuades the hospitals to cooperate with the

regulators in states with ambiguous laws, where the commission's authority to compel information and set precise rates might be resisted, as in Washington. The Commission performs an important planning function, as in Maryland.

4. Screening hospital budgets on behalf of Blue Cross. Most state programs -- mistakenly mixed in with the literature about hospital rate regulation in the United States -- are offices maintained by Blue Cross. Blue Cross pays costs, needs to see the hospital's past expenses and predicted budget, and would negotiate the rate with each hospital bilaterally. The office of the state Blue Cross Plan lacks the staff to investigate and negotiate complicated accounts. It creates an office with such specialists. Cooperation of a hospital is voluntary; if it refuses, it merely fails to get a contract with Blue Cross providing direct payment by Blue Cross of the approved rates. Blue Cross needs the hospital's cooperation, to avoid leaving the subscriber with a substantial out-of-pocket; if the hospital refuses to negotiate, Blue Cross is still obligated to reimburse the subscriber, and therefore it needs a moderate charge that it can pay directly to the hospital in full. By seeming to make the office independent of Blue Cross headquarters, Blue Cross can persuade more hospitals to cooperate. This arrangement exists in twelve states.
5. Screening hospital budgets on behalf of the hospital association. An office of the hospital association then recommends the rates to be asked of payers. Voluntary and advisory. Example is Wyoming.
6. Screening hospital budgets jointly on behalf of Blue Cross and the hospital association. All policy decisions, budget examinations and appeals are handled by committees with equal representation from Blue Cross and the hospital association, with a neutral chairman. Voluntary and advisory, since the individual hospital need not participate. Non-participants do not get Blue Cross contracts, and their patients are reimbursed by Blue Cross at less than the full rates. Example is Michigan.

The scope of regulation is the following. (The rest of this chapter will focus on the state programs, since these are truly regulation.)

1. Medicaid and Blue Cross. Every state regulatory program began by controlling its own Medicaid expenditures. Simultaneously or soon thereafter, it approved Blue Cross rates, to limit the demands filed before the insurance commissioners. Medicare was limited by the payment rules of SSA and HCFA. Rates charged the commercially insured and self-payers were left uncontrolled. Therefore, hospitals could collect shortfalls from them.
2. All payers. Eventually several states extended jurisdiction to the commercially insured and the self-payers. Otherwise those payers would be exploited, the hospital would not be adequately pressed to control costs, and the commercial insurance carriers would be forced out of the market because of excessive premiums or declining benefits. In some states, the same regulatory procedures applied to all -- i.e., the hospital's accounts and revenue were considered single wholes. Examples: Maryland, Washington. In other states, different methods applied to the commercially insured and self-payers. Examples: Massachusetts, New York.

The payment units regulated:

1. Units of service. In all cases, a fair rate is set in the light of the hospital's expected total revenue. Usually a mixture of per diem for basic clinical care and housing, plus charges for ancillary services, but some all-inclusive per diems existed. Examples: Maryland, Washington, and New Jersey exclusively in the past and for many hospitals today. Since neither total revenue nor utilization were controlled, services often exceed the predicted number, and therefore hospital costs rose more than expected.
2. Total revenue of the hospital. The hospital managers then have complete discretion in arranging their services and setting their charges. Example: Connecticut.
3. Maximum charge per type of admission. Developed recently by commissions that were distressed to discover that regulating rates for services does not limit total hospital costs, when hospitals

are free to increase utilization. Examples: Maryland and New Jersey.

Some state agencies regulate all hospitals in the same way. A few have several different programs; for example, all-inclusive per diems for some hospitals and charge per admission for others (New Jersey), charges per service for some and charge per admission for others (Maryland), charges per service and total revenue (Washington).

American regulatory agencies work in two different ways, in health finance as in other fields:

1. Judicial and adversarial. Public hearings occur in every case and are the focus of activity. A record is built up. The organization seeking higher rates submits a detailed application including full supporting data; the application is in the public record, for anyone to study. The applicant is the first to testify in the hearings. Representatives of consumers and any other critics submit statements and testify, if they wish. The hearings panel of the agency asks questions of all sides and asks for additional data. The atmosphere is adversarial although (unlike a courtroom), the parties do not cross-examine each other. Either side can appeal the agency's award: i.e., the applicant, on grounds the award is too low; the consumers, on grounds the award is too high. State insurance agencies hear health insurance rate applications in this manner.
2. Inquisitorial. Public hearings are not routine. The organization seeking higher rates submits a detailed application, including full supporting data. The record is not public. The agency investigates, may or may not communicate with the applicant, and announces its award. The agency's award can be appealed by the applicant as too low. But consumers lack standing to appeal. It is the agency itself, rather than witnesses for consumers, who represents the public interest. All American state hospital rate regulators operate like this normally.

In the United States, judicial and adversarial procedure is considered the fairest way of settling disputes with government and conflicts among private parties. It is mandated by administrative

procedures laws of the national government and (in some form) of all states. Therefore, when hospitals appeal awards in some states, they trigger the convening of public hearings conducted in an adversarial manner. To avoid making their application public, giving third parties a forum to criticize them, and becoming publicized in the newspapers, the hospitals in those states usually do not appeal.  
<sup>15</sup>

The political strength behind hospital rate regulation in the United States has never been strong:

1. Since hospitals were not run by rascals and exploiters, no public outrage was kindled against the entire industry. Such a mood is needed to inspire strong American regulation, from the railroad barons of the 1870's to the polluters of the 1960's. Some reformers thought there were indeed venal people within health care -- viz., many doctors -- but occasional attempts to "expose" doctors did not generate a strong national movement. Except for rascals and exploiters, Americans are most hostile toward politicians and bureaucrats, and therefore the doctors and hospitals could easily rally public wrath against the hospital regulators.
2. Payers have not formed a common front. They are rivals, trying to shift costs to each other by striking tacit bilateral deals with each hospital, by resisting any independent authority. In any activity, it is always difficult to create a stable alliance of equals between government agencies and private organizations. Relations between rate regulation and antitrust laws (both national and state) have never been spelled out; collaboration among payers can be harassed or even forbidden by antitrust suits filed by the hospitals or by government officials.
3. Controlling Medicaid and Medicare costs is not a strong enough motive for regulating hospitals. Another remedy for Medicaid is an action that American taxpayers prefer, viz., capping benefits. Another remedy for Medicare is one that beneficiaries will protest but that hospitals and doctors welcome, viz., more cost-sharing and supplementary insurance by beneficiaries. (Rather than control hospital rates, the Reagan Administration during late 1981 proposed

only to reduce its own expenditures by capping Medicaid, reducing Medicare coverage, charging higher premiums for Medicare subscriptions, and inducing the aged to use more private insurance.)

4. No nation-wide movement existed to adopt the same method in all states, even though the problems were identical. A confusing mosaic resulted, euphemistically described as "demonstrations" and "expressions of American pluralism."
5. The national government never tried to encourage development of uniform approaches in all states, since defenders of local political turf and state hospital associations were too powerful. When the national Executive Branch in 1977 belatedly proposed a policy, it was a temporary measure wholly unrelated to the existing state and private efforts, viz., a cap rising annually and automatically by formula.
6. Many regulatory agencies are weak because:
  - (a) Their statutes are ambiguous in the crucial clauses that state their authority, that state the right of hospitals to charge customers rates not certified by the regulators.
  - (b) Their statutes and regulations are voluminous and complex. Hospitals can resist and can harass the regulators by filing law suits. Under the law and custom in hospital financing, the hospitals can include the legal fees as allowable costs in rates.
  - (c) Some statutes have had "sunset" clauses. They expire unless the state legislature re-enacts them. The hospital association usually can mobilize enough opposition to bottle up a renewal. Colorado's rate regulation suffered such a quick death and (at the time of writing) Illinois' future is precarious.
  - (d) Money comes from mixed sources, and some sources are unpredictable. At various times, all state programs have depended heavily on demonstration grants from the national government. During some years, half their budgets and half their personnel have depended on federal grants; when the grant runs down or when it is cut back, the program must release staff, move into smaller quarters, and drop programs. The result is an air

of impermanence. Some state programs adopt a succession of analysis and regulatory methods, depending on the granting decisions of Washington.

7. Fashions come and go rapidly in American government. Instead of letting any program settle down and instead of strengthening it carefully, Americans (particularly in national government) quickly become disillusioned with them and enact replacements. This instability results from the entrepreneurial style of legislators, eager to attract the attention of interest groups and mass media. It results also from a common tendency to overinterpret the mandate from an election that changes an Administration in Washington. Since the American civil servants can easily be reassigned, agencies and programs can change quickly; the civil servants cooperate with signals from above, instead of trying to preserve their programs.

#### HOSPITAL RATE REGULATION IN EUROPE

Evolution. Once European and Canadian hospitals had the same wide variety of pricing methods as the American. And once there were at least as many payers, with different financial capacities. European, Canadian, and American hospitals practiced price discrimination for identical services, because they had to find the money where they could.

Even before national health insurance, the first regulations by government set prices that everyone was expected to pay, as in France. In countries where hospitals discussed charges with sick funds (such as Germany, The Netherlands, and Switzerland), hospitals adopted the all-inclusive charge and tried to collect it from everyone. A principal reason for national health insurance laws was to create the financial capability of paying for everyone alike for the basic services, regardless of personal wealth. Price discrimination was still possible in private practice. Countries without these standard rates and without sick funds, such as England and Canada, eventually had serious financial crises.

In every other country regulatory or negotiating methods evolved over many decades. They came to fill an important social

function; payers and hospitals took them for granted. If something worked badly, eventually it was reformed, sometimes substantially. But Europe has avoided the American habit of frequent structural change, with tinkering in between.

For example, French hospitals and old-age homes were nationalized during the 1790's.<sup>16</sup> Local governments (the communes) owned and managed the hospitals and used them to house indigents. Eventually money from the social welfare part of the commune budget was transferred into the hospital budgets for each day of care for a patient. This was the forerunner of the modern daily charge (the prix de journée).

The procedure was regularized for the entire country by a law passed by the national Chamber of Deputies in 1893, concerning provision of free medical care to indigents. The prefect -- the representative of the national Ministry of the Interior who oversees local services -- could fix the daily charges paid by public or private welfare programs to the public hospitals, on the basis of an application by the governing board of the hospital. Subsequent decrees of the national government instructed the hospitals and prefects about procedures and methods of calculation.

During the twentieth century, French hospitals became more attractive and more successful in their cures. In contrast to their traditional image as refuges for the indigent, they attracted workers and farmers, who were expected to pay the daily charges. Several hospitals maintained rooms with fewer beds than the large general wards. Decrees instructed the prefect to authorize between 10 per cent and 50 per cent extra for the more private rooms. The prefectures included in their staffs specialists in examining hospitals' retrospective financial reports and prospective budgets. Their task was to ensure a daily charge that covered the hospital's costs and also was fair to the payers. By 1982, every patient belongs to a sick fund that pays the hospital. The prefectures still examine the hospital's finances and set the daily charges. Their motives have become a mixture: ensure that the hospital can recover the costs of appropriate care; protect the finances of the sick funds; and, recently, prevent health prices from fueling inflation. Some changes in the regulatory

system are impending in 1982, since the prefects will lose power and local assemblies will gain. But the regulatory methods will not change drastically, since the tasks remain, and France (like other European countries) tries to preserve and improve existing arrangements.

European countries have quite different methods. France is the best example of rate regulation performed directly by civil servants; this is possible only when the national government has field staffs. In theory, The Netherlands might have developed government rate regulation, since price control laws since 1939 have sought to prevent excessive increases by all private organizations that would gouge customers and inflate the economy.<sup>17</sup> Lacking a nation-wide field staff, the Ministry of Economic Affairs issued guidelines about allowable increases, received lists of prices from providers (including hospitals), and questioned prices exceeding guidelines. The Ministry could order freezes and roll-backs.

This simple capping by formulae seemed badly suited to hospitals, which were supposed to provide whatever services were needed by the community at full costs. Unlike France, the Dutch national government did not employ specialists in hospital finance who could fix a fair amount. Doctors' fees were settled by bilateral negotiations between sick funds and medical associations in Holland and Germany; the latter settled hospital charges by negotiation too; since the sick funds were the principal payers in Holland, they wanted a direct voice in hospital rate-setting. So, a new Dutch law in 1965 combined regulation and negotiation ingeniously. The national government authorized creation of a private negotiating and investigating commission (COZ) that would recommend rates for each hospital, which government might enact in regulations. In practice, government always adopts the recommendations, since they have resulted from thorough investigation of the hospital by a specialized staff and since they have been accepted by the trade unions.

The Dutch commission is a sophisticated organizational form for bilateral bargaining. The governing board consists of nearly equal numbers of representatives from the national hospital association and the sick funds; the national government appoints a few representatives

(distinguished citizens and not officials) to preside, mediate, and cast deciding votes. It is not merely a negotiating forum. It oversees a staff of investigators who analyze the hospitals' financial reports, interview hospital officials, make site visits, and recommend rates. The commission is essential as a liaison between the regulators in government and the private negotiators in health: it receives from several Ministries in the capital advice about national economic policy, it translates the advice into operational guidelines to be used by the investigators, when screening the hospitals' submissions, and it transmits to the national government (currently to the Ministry of Health) rates which clearly have been approved by the leaderships of the hospital and funding sectors. The commission is essential in the internal affairs of the agency: it avoids the common problem of leaving the field investigators and regulators adrift, without detailed guidance and an audience close at hand; it avoids tilting the system toward one interest group, since the board consists of both.

Granting agencies. In some countries, some or all of the operating expenses of hospitals come from the revenue of government. The hospitals remain privately or locally owned. Examples are Switzerland and Canada.

Strictly defined, rate regulation is government arbitration between the competing interests of two private groups, viz., the hospitals and the sick funds. Originally, the granting countries operated much like that: the rate regulators in the cantonal Ministries of Health of Switzerland and the provincial Ministries of Health of Canada arbitrated between the high requests submitted by the hospitals and the professions of poverty from their own payers. The payers were the sick funds and cantonal Treasuries in Switzerland -- their shares are decided in a second step -- and the provincial Treasuries in Canada. The rate reviewers in these governments therefore have always worked much like the rate reviewers in France and Holland: they receive guidelines from economic policy-makers about expected price trends and desirable actions; they scrutinize prospective hospital budgets to detect overstatements; they check that the hospital will get the revenue to provide adequate services; they examine end-of-the-year expenditure

reports to detect waste and mismanagement; and so on. Recently they have become stricter regulators than those in a more private situation (as in France and Holland), because the Swiss and Canadian provincial Treasuries insist that the annual appropriation not be exceeded.<sup>18</sup>

The work of the granting agencies will be described further in Chapter VIII, infra.

Comparisons with American practices. Following are characteristics of rate regulation in Europe that contrast with American methods.

1. It is enacted to mediate between payers and hospital. Legislation bids the regulators heed the interests of both sides as well as the state of the general economy. Regulation is supposed to promote social harmony and order. Since regulation is not enacted as a crusade against one side and accusations about exploiters are absent, it evokes less resistance and fewer maneuvers for repeal.
2. Regulators in Europe operate by the inquisitorial methods, described on page VI-22, supra. Even the courts do not work by the adversarial methods with initiative by the parties and passivity of trial judges, common in the United States. Appeals to the courts existing in Europe occur over the meaning of the statute and over procedural due process, but these are settled during the early years of a regulatory program. Thereafter the regulators can work with full authority, subject to administrative appeals over the fairness of their awards.
3. Since the interest groups lacked political vetoes over legislative passage, usually the statute gives clear authority to the regulators and investigators. Laws and regulations are usually easier to read and understand than American documents; less confusion, fewer disputes, and fewer lawsuits arise over the meaning of clauses.
4. The regulatory organizations are stable over many years. The staffs gradually gain expertise and a personal career commitment to the task. The agencies and civil servants gain the confidence of all sides, become part of the political landscape. They can perfect their techniques without excessive haste. They lack fear of quick repeal or reshuffling if they displease someone. They can ride through the periods of protest that inevitably arise when hospitals

- are being squeezed. Since interest groups cannot abolish an agency, they must work through it.
5. Administrative arrangements become uniform throughout the country. In unitary countries, uniformity naturally results from the terms of the national government's laws and the actions of the national interest groups. But common methods are eventually adopted in foreign federal countries as well, even though in theory every province can create its own arrangements. Uniformity results from indirect effects of national health insurance laws, the tendency of interest groups to try to maneuver over boundaries larger than the individual province, and the tendency of provincial civil servants to emulate each other (even though they believe they don't). The United States is the only federal country that employs rate regulation of hospitals; but, if any others did, they would doubtless become more uniform.
  6. Nearly all hospitals conform. In theory, in most countries they could be exempt from rate regulation, but they would forego direct payments from sick funds, the carriers would reimburse patients little or nothing, and the patients would prefer hospitals with guaranteed direct payment-in-full. Few hospitals can survive entirely privately.
  7. Complicated charges cannot be administered easily and are disputed endlessly. So, rate regulators rely on the daily charge, either all-inclusive or a partial one supplemented by a simple fee schedule. A disadvantage is loss of costing information about individual cases. Considerable cross-subsidization among services results, and a sick fund is burdened if its subscribers cluster in the services that are really less costly. But the system saves administrative costs and trouble. Cross-subsidization in individual cases averages out among sick funds with large volumes, so they really share the hospitals' budgets according to number of patient-days.
  8. Hospitals cannot charge sick funds and other payers different amounts for the same services. Regulations are supposed to fix a fair price for the average citizen, regardless of his carrier.

They never authorize variations in contractual allowance. Sick funds and other payers always presume they pay the official rate and are not likely to pay more voluntarily. Therefore, payers constitute a common front.

9. Every regulatory agency has uniform financing. The French prefectures and their hospital review staffs are paid by the national government. Since it is supposed to be independent of the government, COZ in Holland is supported by a supplement collected along with every daily charge.
10. Fitting rate review of individual hospitals into planning the entire hospital system is difficult. This seems easiest when government money pays for both operations and capital in full.
11. The official regulator announces the rates, often in a published decree. Announcement is not left to the hospital, as in American states. Everyone in a European country knows the rates and is forewarned of changes. As a result, payers can plan ahead. Self-payers can shop.
12. As I will spell out in Chapter IX, infra, the philosophy of foreign regulators differs. In particular, they do not think they are regulating a typical business firm. They do not make sure the hospital "industry" can attract enough capital from a fluid private capital market, by receiving the same "rate of return." Rather, their mission is to guarantee that a nonprofit community institution has the means to perform its services, without waste and without excessive burden on the public's finances.

#### AUTOMATIC FORMULAE

Issue. At times Americans have attempted to avoid imposing new regulatory machinery on hospitals by enacting financial formulae. Hospitals can increase their charges or total revenue each year no more than by the increments resulting from specified calculations from the previous year's figures for spending and utilization. "Provider capture" of a regulatory process is avoided, since no regulators exist and since the calculations are automatic. An official agency is needed

only to check the hospitals' financial reports, apply the computer program with the formulae, and mail the result to each hospital, as its rate or revenue limit for the next year. The same or another agency hears appeals by hospitals claiming special reasons for more money. The agency does not negotiate with or investigate individual hospitals before setting the rates, a laborious and judgmental task performed by the normal regulatory body. The only advance negotiation consists of meetings among the government agency, hospital association, and sick funds to agree on a formula at the start of each year.\*

These methods were used in the Economic Stabilization Program, to fix allowable revenue increases for all hospitals each year. The methods also were proposed in the Carter Administration's Hospital Cost Containment bill of 1977 and in several substitutes by Congressmen.<sup>19</sup>

The method has been used for a decade in New York State in setting prospective rates for Medicaid and Blue Cross.<sup>20</sup> A simplified version is used by the Massachusetts Rate Setting Commission when scrutinizing and controlling Medicaid charges, but the Commission performs the normal budget review by a regulatory agency for other payers.<sup>21</sup> The starting point is the total costs for the last available year, plus a percentage increment that estimates rising prices and rising wages. (Wage increases due to collective bargaining contracts may be passed through.) Several additional formulae are disincentives to underutilization and excessive utilization. For example, as a disincentive to operate an underutilized hospital or to keep unnecessary beds open, the number of beds for calculating the daily charge is at least 80 per cent or 85 per cent of full occupancy. This figure is divided into the total expected costs to get next year's daily rate. If an underused hospital could use its actual number of patient-days, then its daily charge would be higher. The formula is an incentive to reduce costs. Other formulae penalize increasing patient-days beyond

\*The meetings provide one of the few opportunities -- indeed, necessities -- for the payers in the United States to meet together and work out a common front. During the debate with the hospitals in New York and Massachusetts, Blue Cross and the state government (i.e., the Medicaid administrators) clearly share a common interest in restrictive formulae.

the start-of-the-year expectations, and penalize number of patient-days beyond the average for hospitals of the same type.

General formulae penalize hospitals financially if they deviate too far from their peer groups. The grouping itself is created by a computer program clustering from several organizational characteristics of all hospitals.

Difficulties. The American national and state Constitutions guarantee "due process of law" to the regulated; regulatory custom and laws guarantee to the regulated that their treatment is "fair" and "reasonable." In theory, the method of automatic formulae removes all arbitrariness: all sides in New York participate in the special committees that review and approve the method; the computer applies the formulae to each hospital's prospective budget, eliminating the potentially capricious regulators.

Instead of reducing complaint, the automatic calculations increase it. Prolonged review and discussion of individual cases between hospital managers and regulators before a ruling can mollify the directors, settle disputes (particularly over whether the hospital is a special case), and reveal bugs in the methodology. Automatic application of formulae by a computer eliminates the personal adjustments between two groups of health administrators, and many disagreements have been handed over to lawyers, who escalate the issues and take them into appeals agencies and courts.

Constantly under attack for unfairness, the formulae are frequently "improved." Often this merely means that the representatives of one faction in the joint formula-monitoring commission have been appeased. Reading the New York State manual, one is struck by the enthusiastic descriptions of each year's revisions. The American taste for innovation and change extend to the rules of the game. After the hospital director thinks he finally understands the procedure, it changes.

At times, formulae are proposed and even adopted that are unusually difficult to understand and remember. (For example, essential parts of the Carter Administration's Hospital Cost Containment proposals.) If certain formulae are difficult to understand, they are

no more "reasonable" than anyone else's scheme. They will probably produce unexpected outcomes. Hospital managers and doctors cannot respond to incentives that they do not understand.\*

The unexpected difficulties created by transferring a research model into the practical world are illustrated in the case of peer grouping. A common-sense method is to put together in one group all hospitals most similar in size, location (urban, town, or rural), ownership (government, confessional, lay nonprofit, and proprietary), function (teaching or nonteaching), and in complexity of services (many or few clinical departments). A hospital often complains that it is not classified with its true peers but should be in the more advanced (and more expensive) category.

Finding the best possible grouping system is one of the Holy Grails in American medical econometrics, and factor analysis and clustering programs are run on data tapes with many organizational and clinical characteristics of hospitals. The result is to classify each hospital with its "true" peers. The peer grouping is an artifact of the procedure and of the contents of the input file, and the slightest changes in either can produce great results in the definition and membership of groups. Input or methodological changes can be the addition of a few new hospitals not included in earlier computer runs; a change in any hospital's characteristics; changes in weights given to variables; increase or decrease in the number of groups desired; changes in the treatment of missing data; and so on. Therefore, a hospital may be bidden by the penalties and incentives to operate like others in its group, but it is often assigned by the computer to a group of total strangers. Next year, the method creates different groups and the hospital manager must make different comparisons. The manager may not have liked the class to which he was assigned by the old-fashioned common-sense method, but at least he understood it and could argue about the results. Now he is assigned by a machine tended by young technicians speaking a strange tongue. New York State at the time of

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\*A substantial number are baffled by such formulae and misinterpret them even in states with regulatory agencies staffed with enough persons to check their understanding and explain.<sup>22</sup>

writing in 1982 is debating these unexpected outcomes of its elegant "seed clustering" method.

The formulae usually include ceilings or declining reimbursement rates, to discourage high volumes of use or to discourage high unit costs. Whether a hospital is affected depends on its relative position in its peer group, and its position within the group as well as its assignment among groups depends on the data submitted by all of them. A hospital might assume that its revenue for the year is fairly well known, but then it gets an unexpected shock when the fully audited final expenditure statements are processed through the computer programs months later. The hospital may be subject to unexpected reductions in the expected full reimbursement, because it unexpectedly exceeded the ceiling. Meanwhile, the managers have gone well into the new fiscal year, with a level of operations they had assumed was within the ceilings but which now seems destined for a second year of penalties. Other hospitals get unexpected financial windfalls: they seemed subject to the ceiling penalties under the interim calculations but are paid in full when the finally audited data are run for all hospitals. By then, managers have cut operations to stay within limits that no longer apply to them. They must decide whether to restore cuts.

Because different payers have different allowable costs, different payers have different formulae, adding to the complexity. In particular, the application of the stepdown differs. In each year, New York's Medicaid program and Blue Cross come steadily closer together, but the difference in allowable costs still required small differences in 1981. The different formulae are applied to the same data base, since the hospital's past cost reports are aggregated and are not divided separately into accounts for Medicare, Medicaid, Blue Cross, etc.

The United States government as payer under Medicare uses formulae to make several allocation and cost containment decisions. Committed to pay "the reasonable cost . . . incurred . . . in the efficient delivery of needed health services," Medicare restrains the peer group average and discourages waste by flatly paying no more than the 90th percentile of routine daily patient care costs in each class.

Medicare therefore does not pay the most expensive hospitals in full. But the formula applies not to the total cost structure and revenue of the hospital, only to Medicare payments. Therefore, it triggers many of the perverse effects of America's multiple payment system. Other payers in those hospitals pay either in full or even more, to carry the costs not reimbursed by Medicare. During the juggling, the hospital's finance officers may rearrange the charge structure, increasing prices in those ancillary services heavily used by Medicare patients. The hospitals try to collect the unreimbursed money from Blue Cross,<sup>23</sup> the commercially insured patients, and the self-payers.

Accomplishments. If the goal of policy is to limit the increase in hospital spending, the method of automatic formulae can be more successful than any other approach to per diem payment. The formulae cut down the high spenders who raise the average and set a bad example. The formulae penalize overcapacity, reward reductions. The administration provides no regulators who listen sympathetically and make concessions. As a result, New York State during the mid-1970's -- despite difficulties in implementation -- had smaller annual increases than other states. Increases in cost per admission for the period 1975-1978 were:<sup>24</sup>

|   | <u>Per Cent</u> |
|---|-----------------|
| Entirely formula (New York)                                       | 26.28           |
| Mixture of formula and regulation by<br>an agency (Massachusetts) | 41.55           |
| Regulatory agencies:  |                 |
| Connecticut   | 37.98           |
| Maryland  | 36.18           |
| New Jersey  | 37.08           |
| Washington  | 45.38           |
| All other states  | 49.25           |

Automatic formulae are not as automatic in application as one expects. When the computer announces disappointing news, many hospitals automatically complain and file law suits. Without a regulator to talk things over and confronted by administrators who say their hands are

tied, the hospitals are quick to sue. During the aforementioned period 1975-1978, the increases in New York state would have been even lower, except that the administrators made many concessions to individual hospitals and granted many general interim rate increases, out of political prudence or to defuse court cases.<sup>25</sup> Fighting an impersonal system is worthwhile, since the hospitals can count the legal costs in their base for cost-based payers.

Current methods abroad. Statistical formulae are commonly used by regulators in Europe. They are spelled out in guidelines memoranda from the national Ministry of Finance and Ministry of Health. As in the United States, they are designed: to discourage hospitals from running costs in excess of relationships to certain independent variables, such as beds, patient-days, or size of community; to discourage maintenance of underused capacity; and to discourage levels of cost and utilization in excess of peer group averages. They are a series of two-variable relations, such as the maximum person-hours in nursing at different levels of patient-days or of admissions. They are close to what a hand-calculator would do at his desk, so that every step in the groupings and analysis are comprehensible to everyone. They are not multi-variate and rarely curvilinear, and Americans might deem them insufficient in "sophistication" and "rigor."<sup>26</sup>

The formulae in Europe are not a substitute for judgment by a staff, they do not make a regulatory agency unnecessary, they are not supposed to realize perfect rationality. They are used for screening and as a basis of discussion with the hospitals. Every hospital's last expenditure report is computerized to produce the data base yielding the peer group averages, for those comparisons. In most offices, the prospective budgets and rate applications are also computerized, so a computer program rather than manual calculations can spot the outlyers whose statistical relationships (such as average occupancy or average length of stay in acute services) are above or below the guidelines. To save time, the regulators concentrate on the outlyers and review the others quickly (as in a French DDASS) or review the others not at all (as in Holland's COZ). When the civil servant confers with the hospital over the budget, he asks why the hospital deviates so far from the

formulae in the guidelines and so far from the peer group averages. Without special justification from the hospital, the rate application is cut.

Peer grouping in Europe is invariably simple and easily understandable to health administrators and the laymen in governments. Hospitals are grouped according to a few simple dimensions, such as bed size, clinical character (acute, psychiatric, etc.), educational function (university-affiliated or not), and region. Hospital managers in the same group are expected to compare methods, so they are similar in costliness and quality; and they are encouraged by regulators to share facilities, such as laundries and laboratories. Holland's National Hospital Institute holds regular meetings of the directors of members of each group, so they can review each other's methods. The grouping methods and assignments are stable.

In many respects, financial procedures abroad are kept stable, so that everyone can learn them and so that true problems can be distinguished from temporary ones. Minor tinkering every year is avoided, unlike the penchant for change in the United States. Since it is not possible to please the regulated persons, it is deemed better to have stability than to invite chronic uncertainty and new disputes.

At first sight, the foreign regulatory agencies use formulae like their American counterparts, as in the Maryland and Washington commissions and in New Jersey's SHARE. The American agencies use the formulae for screening, since they must concentrate on a few cases: they must pass most dossiers falling within acceptable limits and must prepare elaborate justifications of the disallowances, to hold up in lawsuits. Any foreign agency faced with a very large workload (such as Holland's COZ) also uses computerized searching by formulae to pass the routine cases and find the troublesome ones. But the American methods are so much more complex and changing that they often seem like research projects rather than serious regulation of an economic sector.

Closest of any foreign country to the United States geographically and intellectually, Canada -- and particularly Quebec -- has applied American computer programs and econometric formulae to its special problems. In particular, when is a hospital's costs high

because of waste, provider-induced overutilization, or justified community-inspired utilization? Answers to the question determine how the Ministry of Social Affairs distributes its budget to the hospitals of Quebec. The outcome of the calculations is a permanently reduced or an increased budget base. Peer group comparisons are essential; the grouping variables include the frequency of diagnosis; and a computer clustering program groups hospitals by clinical profile as well as by other variables. Other programs compare the hospital with others in the group<sup>27</sup> to identify types of outlier. Determination of the provincial Ministry's annual payment to the hospital is not an automatic calculation by the computer, but personal investigations by the civil servants and negotiations then follow.

When reviewing an individual hospital, the regulatory or budget allotment problem is the amount of new money it should receive beyond the current year's budget. This involves comparisons with peers and with the theoretical outcomes of formulae. Distributing a large national health budget encounters different calculating problems, viz., the amount "deserved" by each region. Stakes are very high, since the distribution formula is always designed to reverse previous concentrations of spending. Great Britain devised the RAWP formulae to distributing operating and investment money, in a manner that would seem reasonable to planners and politically fair to communities. They had to be comprehensible, since the Minister would have to defend their logic and results every year privately in Cabinet and publicly in the House of Commons. They had to be fine-tuned, to cushion severe effects on the overprovided regions and to avoid giving the underprovided more money than they could use. Satisfactory formulae were devised and are used with some flexibility each year to allocate the budget of the National Health Service among regions. More elusive are measures of regions' differential needs for facilities, defined from morbidity and not merely from traditional utilization.<sup>28</sup>

## LESSONS FOR THE UNITED STATES

## 1. Health regulation in general

(a) Sweeping generalizations about all regulation in health are futile. Perhaps regulation applies to one common situation with a fixed set of actors in the average business setting. But health services involve many different activities performed by different organizations with different purposes. It is not possible to do "everything" by one or another theoretical extreme -- i.e., by "regulation" alone or by "free market" alone. The different activities are influenced by a varied mix of public and private actors, by a mix of orders and incentives.

Regulation itself is a mixture. It is never conducted by direct orders alone, particularly in health care, where laymen defer to the technical expertise and mystique of the insiders. Regulators must persuade as well as order.

- (b) Like every government agency, a regulatory body is the object of pressures from competing interests. Sometimes it is "captured" by providers, at other times by other groups. The orientations of a government's regulatory bodies at any one time are diverse. Permanent capture by one group is unusual.
- (c) Health regulation need not be permanently captured by providers. Consumers are better organized in health than in other industries. Sick funds can be a countervailing power monitoring the regulators of hospital payment.
- (d) Regulation can be neutral if a country's civil service is secure and stable. The regulators are not tempted by revolving doors.
- (e) Stability in organization, rules, and decision-making procedures enable a regulatory agency to develop authority, expertise, and general acceptance. Frequent tinkering by the legislature creates uncertainty and invites litigation. Also, it invites political pressures by the competing interests, since each thinks it can come out with new advantages.

Stability is necessary for the hospital managers and doctors to learn the incentives that they are supposed to respond to.

- (f) A regulatory agency can be a consensus-builder among the social forces serving on its governing board, such as trade unions and business. If it is well led, supported by the legislature, and supported by important social forces, it can become a respected neutral arbitrator among interest groups (e.g., between hospitals and sick funds), instead of an avenging angel of "the public interest," punitively bringing rascals to heel.
- (g) Regulation need not be conducted in isolation, subject only to the vague mandate in its original statute and the day-to-day pressures of the interest groups with much at stake. Regulation is merely government in action, and can be aimed at any public policy goal. Planners and policymaking executives can draft guidelines in accordance with larger plans and can then send them to the regulators. Compliance with the guidelines can be obligatory or voluntary, depending on the statute; voluntary compliance may be diligent or weak. The results can expand, contract, or rearrange services; new entrants can be helped or hindered. Appropriate information feedback can tell the policymakers about implementation of the guidelines. Therefore, it is feasible to tie hospital rate and revenue regulation to a government's economic policy -- if it has one.

American health regulation -- like other American regulation -- suffers from unstructured and ambiguous relations to the larger government. Regulation is often made "independent," which deprives the agency of firm political allies, assigns it no procedure for accountability, leaves it to respond passively to industry or consumer pressures. The government-of-the-day lacks a policy in the regulated field, to guide the agency. (Indeed, creating a regulatory agency is a familiar method in the United States of "getting rid" of an issue.) The regulatory agency is not left alone in a clear setting, in

order to develop procedures and understandings with the interest groups, but its mandate, external relations, and staffing are frequently changed.

The "revolving door" for leading regulatory personnel is created in large part by the instability of the parent government, which has no policy other than reshuffling personnel after each election. Without a secure base and purpose, the regulatory personnel have no shelter except in the health industry itself.

- (h) If governments must develop policies to guide the regulators, the political parties become less opportunistic in wooing the interest groups, less obligated to reshuffling the interest groups' tormenters and installing their spokesmen in regulatory posts. In health, the parties may find that they share many of the same policies, and that an effective regulatory machinery must be left in place regardless of elections. Confusing reshuffles without a rationale in policy -- but with various unintended policy consequences -- become less common in regulatory agencies after elections.
  - (i) Nation-wide uniformity is often hindered in federal countries, because regulatory power in health rests with provincial governments. However, high uniformity in hospital affairs -- as in other fields that seem too large for provincial boundaries -- can be achieved if the provincial governments, the hospital association, and the payers so desire. The associations may promote national styles in management and reporting.
2. Regulating the payment of hospitals
- (a) Generosity to the hospitals results usually because the statute guarantees recapture of their costs, not necessarily because regulation is always stacked on behalf of the providers.

A regulatory program can be stacked on behalf of victims or consumers, but then eventually people no longer are interested in becoming providers. Then the biases in the statute and in regulatory administration will probably change, to preserve the service.

- (b) Regulating hospital payment differs essentially from rate regulation in other fields. It is a form of cost and volume control over an entire industry. It guarantees survival of facilities. Regulators constantly second-guess management. This regulation protects the solvency of sick funds and reduces pressures on the regulators who monitor their premiums.

Regulators of payment in other fields are concerned with other objectives, such as fair -- but not excessive -- rates of return on capital. They protect consumers against extortion. But otherwise, consumers and the firms are at risk. In capitalist economies, regulators are careful not to intrude upon management, not to learn too much about the internal affairs of firms. Fitting revenue exactly to costs is rarely attempted in regulation outside of hospital finance.

- (c) American hospital payment regulation is often pressed to emulate private utility regulation. I.e., minimum attention to managerial details and concern only with financial results. But hospital regulation can be less contentious and more creative if regulators are aware of every hospital's internal affairs and community functions. American hospital rate regulation is too preoccupied with controlling spending and charging. A constructive interest requires assigning each staff member in the regulatory agency to particular hospitals.
- (d) American preoccupation with hospital regulation that is "just," "reasonable," and defensible in court leads to a constant series of small concessions to the hospitals. The possibility of winning concessions invites complaints and demands. Private business firms are more inclined to adjust to new price awards by operating within them, since they know that the next increase will not come soon.
- (e) Regulating the premiums of insurance carriers is a weak lever over health care costs.
- (f) If construction and heavy equipment are paid for by public grants rather than self-financed by the hospital itself, the

regulation of hospital affairs -- both facilities development and operating costs -- is greatly simplified. Self-financing gives the hospitals the initiative, and it can present regulators with a fait accompli. If investment comes from a public fund, investment planning for health services generally and rate determination for individual hospitals can be coordinated more easily.

- (g) The several regulatory programs should be coordinated, or each becomes weak. For example, facilities regulation needs backing from the payment mechanism -- i.e., operation of an unauthorized facility will not be paid.
- (h) Complicated payment units breed confusion and dispute. Different pay rates for different payers are difficult for a regulatory agency to administer. Complicated payment systems by the hospital and complicated awards by the regulator result in possible manipulations that the regulator would have avoided, such as price discrimination among third parties, cross-subsidization among services within the hospital, juggling of reports about costs.
- (i) Regulators everywhere are in a constant cat-and-mouse relationship with hospital finance officers, over the accuracy of reports, cost assignment, concealment of revenue, and so on. But regulators or grantors abroad at least have the feeling that they are close to the whole story, since they examine the hospital's entire finances and fix a pay rate determining nearly the hospital's entire revenue. But American regulators have the uneasy feeling that they know more about certain sectors of the hospital's accounts than of others; the hospital manager is free to set many charges and find revenue without reporting them to the regulator. Some state laws give the regulator authority only over certain accounts and payers -- or stronger authority over some than of others -- and the regulator has the uneasy feeling that he is being outmaneuvered. As a result -- if the statute permits him to be strict -- the American regulator may not believe the hospital manager's

dire predictions but may assume that every manager can find unreported money.

3. Automatic formula methods:

- (a) Can be designed to control costs and utilization more strictly than regulation, since they lack regulators empowered to make concessions. But if the method is adopted in a country or region with high costs earlier, the trend factors for inflation will still produce high results. The results may not go as high as under another method. No method can roll back hospital costs.
- (b) Produce more rather than less contention.\* Lack opportunities and personnel for negotiation, mollification, and the building of consensus. The only discussions are in the formula-writing committees, not between individual hospitals and the civil servants. The atmosphere becomes highly adversarial in the committees, where everything is at stake for the entire industry. Adversarial conflict grows, because the aggrieved hospital has no alternative but a formal appeal and a lawsuit.
- (c) Because of its potentially tough restraint on costs and limited scope for informal appeals, the method is favored by payers and opposed by hospitals.
- (d) Payers and hospitals lose their autonomy to the formula-writing committee and to the technicians at the computer center.
- (e) If automatic formulae or strict regulation can limit annual increases in a hospital's total costs, payments to cost-based payers rise slowly. It is not cost-based reimbursement that causes hospital costs to rise steeply but the combined behavior of the hospital managers, the doctors, the sick funds, and (if any) the government regulators.

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\*Therefore, in the long run, it produces higher costs and more administrative effort than appear at first sight. The New York State Council on Health Care financing recommended retention of the state's formula method rather than adoption of a regulatory system, on grounds that prospective budget review of over 300 hospitals is too troublesome and expensive. However, fighting several dozen in court each year may be even more expensive to both the soul and the Treasury.

Regulation of a private sector abroad can accomplish similar outcomes as in the United States, often with fewer detailed documents, fewer conflicts in implementation, fewer end runs, greater flexibility by the administrators and field staff. These outcomes require: greater stability of agency leadership; nonpartisan neutrality and expertise by the leadership; a persuasive rather than a generally punitive role by regulators; willingness of the regulated to cooperate rather than evade and fight; intermediation by the interest group leaders over members, to persuade them to adjust creatively rather than merely fight and evade (i.e., a conscientious "Voluntary Effort"); more bilateral negotiation and less adversarialness; less reliance on judges. These outcomes depend on the wider political and social styles of a country. But even though the United States cannot conduct its regulation exactly like a very different foreign society, it need not exaggerate its distinctive tendencies.<sup>30</sup> Regulation can be performed more constructively.

## FOOTNOTES

1. The quotation is from President Ronald Reagan, speech to the International Monetary Fund, 29 September 1981.

2. The principal work during the last round of anti-regulation was Marver Bernstein, Regulating Business by Independent Commission (Princeton: Princeton University Press, 1955). A survey of all the critical literature from all periods is Daniel J. Fiorino and Daniel S. Metlay, "Theories of Agency Failure," paper delivered at the annual meeting of the American Political Science Association, 1977.

3. These points appear in several articles by Louis Jaffe, such as "The Independent Agency -- A New Scapegoat," Yale Law Journal, Volume 65, Number 7 (June 1956), pp. 1068-1076. An empirical test and refutation of the theory that all agencies follow the same declining life cycle is Kenneth J. Meier and John P. Plumlee, "Capture and Rigidity in Regulatory Administration," paper at the annual meeting of the American Political Science Association, 1977. For an empirical research project refuting the generalizations about universal regulatory capture by providers and describing the many agencies that are neutral or are captives of consumers, see Paul J. Quirk, Industry Influence in Federal Regulatory Agencies (Princeton: Princeton University Press, 1981).

4. Extended discussions and evidence along these lines appear in James Q. Wilson (editor), The Politics of Regulation (New York: Basic Books, 1980); and Eugene Bardach, book about enforcement in social regulation (New York: The Twentieth Century Fund, forthcoming).

5. Stephen G. Breyer, "Analyzing Regulatory Failure," Harvard Law Review, Volume 92, Number 3 (January 1979), pp. 547-609.

6. For example, Walter McClure, "Structure and Incentive Problems in Economic Regulation of Medical Care," Health and Society, Volume 59, Number 2 (1981), pp. 107-144; papers by Roger Noll and Clark Havighurst in Controls on Health Care (Washington: Institute of Medicine, National Academy of Sciences, 1975); and Paul L. Joskow,

"Alternative Regulatory Mechanisms for Controlling Hospital Costs" (Cambridge: Department of Economics, Massachusetts Institute of Technology, 1980).

7. Excellent summaries of the problems, regulatory organization, and regulatory implementation in drugs, occupational safety, and environmental protection are in Wilson (editor), The Politics of Regulation (op. cit., footnote 4, *supra*), Part III.

8. FDA's problems with food additive policy are analyzed in Lester B. Lave, The Strategy of Social Regulation (Washington: The Brookings Institution, 1981), Ch. 4.

9. Alfred A. Marcus, Promise and Performance: Choosing and Implementing an Environmental Policy (Westport, Conn.: Greenwood Press, 1980); and Alfred A. Marcus, "Measuring and Analyzing the Growth of Regulation," unpublished paper delivered at the American Political Science Association convention, 1981.

10. Ronald Reagan, comments at a Round Table, in Regulatory Reform: Highlights of a Conference on Government Regulation (Washington: American Enterprise Institute, 1976), p. 59; Secretary Richard Schweiker, speech to convention of the Pharmaceutical Manufacturers Association, April 1981; and Comptroller General of the United States, FDA Drug Approval -- A Lengthy Process That Delays the Availability of Important New Drugs (Washington: General Accounting Office, 1980), pp. 30-44 and 74-76. The GAO's report includes FDA's critique of foreign methods.

11. A description of the compliance efforts in American hospital is Cost of Regulation: Report of the Task Force on Regulation (Albany: Hospital Association of New York State, 1978).

12. Comptroller General of the United States, The Medicare Hospital Certification System Needs Reform (Washington: United States General Accounting Office, 1979).

13. Descriptions of the American state programs are in Abt Associates, First Annual Report of the National Hospital Rate-Setting Study (Washington: HCFA, 1980), 10 volumes; and in Emily Friedman, "State Rate Review," Hospitals, Volume 54, Numbers 5 and 6, 1 March and 16 March 1980. A handy summary of the Abt investigation is in

Diane Hamilton (editor), "Rate Regulation," special issue of Topics in Health Care Financing, Volume 6, Number 1 (Fall 1979).

14. See the self-description by a member of the Commission in Massachusetts in Friedman, "State Rate Review," op. cit., (footnote 13, *supra*), 1 March 1980, p. 58.

15. Examples described in two Abt Associates volumes from their National Hospital Rate-Setting Study, Case Study of Prospective Reimbursement in Maryland, pp. 54-55 and 90-91; and Case Study of Prospective Reimbursement in Washington, pp. 27-29 and 66-78. (Both Washington: Health Care Financing Grants and Contracts Report, 1980).

16. Glaser, Paying the Hospital in France.

17. Glaser, Paying the Hospital in The Netherlands.

18. Glaser, Paying the Hospital in Switzerland and Paying the Hospital in Canada.

19. ESP is described in Paul B. Ginsburg, "Inflation and the Economic Stabilization Program," in Michael Zubkoff (editor), Health: A Victim or Cause of Inflation? (New York: PRODIST, 1976), pp. 31-51. The several formulae for a national hospital cost restraint policy during 1977 and 1978 are described in David S. Abernethy and David A. Pearson, Regulating Hospital Costs (Ann Arbor, Mich.: AUPHA Press, 1979), *passim*.

20. Described in Abt Associates, Case Study of Prospective Reimbursement in New York (Washington: Health Care Financing Grants and Contracts Report, 1980). The formulae for each year are described in Hospital Reimbursement Methodology (Albany: Office of Health Systems Management, annual); and Prospective Reimbursement Method (New York: Blue Cross and Blue Shield of Greater New York, annual).

21. Abt Associates, Case Study of Prospective Reibursement in Massachusetts (Washington: Health Care financing Grants and Contracts Report, 1980); and "Medicaid Reimbursement: A Brief Summary" (Boston: Massachusetts Rate-Setting Commission, annual).

22. For example, Abt Associates, Case Study of Prospective Reimbursement in Maryland (op. cit., footnote 15, *supra*), p. 95.

23. The limitation is explained in the Medicare Provider Reimbursement Manual (Washington: HCFA, 1978 et seq ), Ch. 25,

Sections 2520 et seq. The resultant juggling is described in Graham Atkinson and Jack Cook, "Regulation: Incentives rather than Command and Control" (Baltimore: Maryland Health Services Cost Review Commission, 1980, paper delivered at a conference of the American Enterprise Institute), pp. 9-15.

24. Original data from the Johns Hopkins Center for Hospital Finance and Management, summarized in Brian Biles et al., "Hospital Cost Inflation under State Rate-Setting Programs," New England Journal of Medicine, Volume 303 (18 September 1980), pp. 664-668.

25. Hirsch S. Ruchlin and Harry M. Rosen, "The Process of Hospital Rate Regulation: The New York Experience," Inquiry, Volume 18 (Spring 1981), pp. 70-78.

26. No foreign regulatory or negotiation system uses anything like the predicted cost model of the demonstration projects of Blue Cross of Western Pennsylvania. Abt Associates, Case Study of Prospective Reimbursement in Western Pennsylvania (Washington: Health Care Financing Grants and Contracts Report, 1980), pp. 29-31.

27. Glaser, Paying the Hospital in Canada, Ch. VII, pp. 11-25.

28. Glaser, Paying the Hospital in England, Chs. VI and VI.

29. Council on Health Care Financing, Recommendations for Financing Hospital Inpatient Care (Albany: The Council, 1980), pp. 101-102.

30. The United States is compared to a country with different regulatory methods but similar outcomes in Steven Kelman, Regulating America, Regulating Sweden: A Comparative Study of Occupational Safety and Health Policy (Cambridge, Mass.: The MIT Press, 1981). While substantive results are similar, Sweden has less conflict, lower overhead costs to cope with disputes, and a more stable policy.

## CHAPTER VII

### NEGOTIATION

Without a regulatory agency, the hospital's business office sets its own rates and collects what it can from patients. Large third parties are unwilling to accept the provider's prices uncritically, in health or in any other field. Bilateral discussions are conducted over the terms of sale and over prices. No government or private agency acts on behalf of the hospital and sick fund, although each side may use its own advisors. Government's role is limited to setting some ground rules for the negotiation and enforcing its outcome. At least at first, each third party negotiates by itself. One result is different rates for different payers, according to their market power and according to the hospital officials' biases. The desire to avoid such outcomes is a motive for rate regulation.

### DEVELOPMENT IN THE UNITED STATES

Bilateral negotiation between carrier and individual hospital is the typical method of setting rates for Blue Cross throughout the country. Plans sprang up during the 1930's as intermediaries between hospitals and patients. The pools of money solved the hospitals' collection problems; the patients could count on help with their bills. Some state Plans began as consumer movements, others were fostered by hospitals. Since all were designed to minimize patients' out-of-pockets, all tried to make benefits equal charges and all eventually tried to arrange direct payment to the hospital without initial expenditure by the patient.<sup>1</sup>

Achieving payment in full by a third party required direct agreements between Blue Cross Plans and individual hospitals. They agreed on contracts specifying relationships, eventually following models developed by the state (or regional) Plan office and the state (or regional) hospital association. They also agreed on rates to be

paid that hospital and created a joint reimbursement committee to handle problems and disputes. The negotiation procedures were never officially standardized: each state Blue Cross Plan has worked quite separately; a familiar American idea is that every hospital is "unique," and therefore the state Plan approaches each one in a slightly different fashion.<sup>2</sup> Nevertheless, the visitor to many Blue Cross offices notices similarities in their dealings with hospitals.

The communication load for Blue Cross mounted during the 1960's. Many Plans had already been persuaded by the hospitals to base their payments on a reimbursement of full costs, not on a fixed price set after quick bargaining. Cost reimbursement required study of the hospitals' financial reports and prolonged highly technical discussions. The volume of work skyrocketed: Blue Cross covered many more workers and dependents; Blue Cross became the fiscal intermediaries for several other programs with cost-based reimbursement, viz., Medicare, the Federal Employee Health Benefits Program, CHAMPUS, and some state Medicaid efforts. The 1960's were the period of rapidly increasing hospital costs, and Blue Cross experienced constant financial strains. Discussions with hospital officials continued as amiable as before, but they led to constantly more expensive commitments and annual applications to state insurance commissioners for higher premiums.

During the 1970's, state Blue Cross Plans had to become more independent and more critical of hospitals. State insurance commissioners no longer automatically granted higher premiums. A few specifically ordered hospitals and the state Blue Cross Plan to create negotiating machinery as a condition for premium increases and told Blue Cross to drive harder bargains over allowable costs and over rates.\* Blue Cross for the first time worried about pricing itself out of the

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\*In particular, guidelines issued from 1971 through 1973 to Philadelphia Blue Cross by Pennsylvania State Insurance Commissioner Herbert Denenberg. Convinced that Blue Cross had failed to confront the hospitals on the issues that raised costs, the Commissioner specified topics to be covered in negotiations and in contracts.<sup>3</sup> Where the Blue Cross Plan and state or regional hospital association have worked out a model contract accepted by participating hospitals, most state insurance commissions ask that it be filed along with Blue Cross' applications for higher premiums.

market; it faced price competition from commercial insurers who kept premiums lower by merely reimbursing patients according to an indemnity schedule.

Throughout the country, Blue Cross Plans and state or regional hospital associations created procedures for examining the records of the hospitals. Last year's costs were reported by the hospital to the fiscal intermediary -- usually Blue Cross -- under the Medicare law. If the hospital wanted a per diem that would guarantee its costs -- i.e., a generous prospective rate with end-of-the-year corrections -- it had to agree to send Blue Cross a detailed budget, statistical projections, and an explanation for its plans. It had to agree to a Blue Cross audit. Even if Blue Cross paid only "charges," these were "controlled charges" related to some estimate of costs, and therefore the Plan and hospital had to work out a mechanism of communication. The plans hired staffs to examine the papers and confer with the hospitals. The negotiations concerned only the rates for Blue Cross patients.

#### DIFFICULTIES

Negotiating posture. The role of Blue Cross vis-a-vis hospitals has always been ambiguous, and the role in rate-setting has been unclear too. State Plans have varied in whether they are collection agencies for hospitals or representatives of consumer interests. These roles have changed from time to time. It has been impossible to produce a clear and stable system for negotiations within many states, let alone a nation-wide pattern allowing the sharing of experience. Often Blue Cross and hospitals have really been collaborators in negotiations for more money from state insurance commissioners. Or, Blue Cross has been the spokesman for hospitals in negotiating health care packages with employers.

Since many Plans have tried to gain the cooperation of hospitals and since many hospital directors perceive them as collection agents who otherwise should "keep their place," many Plans long worked out reimbursement agreements on the basis of the hospitals' simple documentation, without intruding too deeply into the hospitals' files. The negotiations

recently have become stricter out of financial necessity, and the Plans now have funds to employ staff members conversant with hospital finance, but Blue Cross in some states still must hedge. It lacks a powerful sanction to force hospitals to agree: if no contract is signed, the patient may still go there, and Blue Cross must still reimburse him most (perhaps 80 per cent) of his costs. The patient is left with out-of-pockets as a result, he will probably blame Blue Cross rather than the hospital, and the patient may switch to another carrier that pretends to offer more benefits. Unless the state Blue Cross Plan has a charge-based reimbursement method -- i.e., a definite warning to subscribers that full payment is not guaranteed -- it may buy peace by giving the hospital much of what it wants. But the hospitals don't get everything.

If negotiations do not yield rates and costs that a Blue Cross Plan can meet within the rate structure allowed by the insurance commissioner and by its contracts, it must back away from its paid-in-full and direct-payment aspirations. It would offer only charge-based reimbursement to the patient or to all the hospitals, with the latter collecting the balance from patients. If this option is adopted widely, only limited negotiations are necessary with the hospitals: they discuss the procedural clauses in contracts and Blue Cross tells the charges it can afford to cover, with the patient and hospital setting the rest between themselves. As hospital costs rose during the 1950's and 1960's, some Blue Cross Plans backed away from cost-based payment-in-full and resumed primary reliance on charge policies. Of the 71 Plans responding to the AHA's survey in 1979,<sup>4</sup> 39 paid charges and 32 paid costs. The charge-payers were usually (not entirely) in states with weaker unionization, fewer group contracts, lower Blue Cross market penetration, and charge-based reimbursement for most patients. Blue Cross there must avoid expensive commitments and high premiums.

Information. Normally a problem in any negotiation is information. Each side needs it to judge the merits of the other's claims and his true capacities. Each presents documents and statistics, but they are self-serving ammunition. Representatives of workers and consumers often ask to see the adversary organization's accounts, but they are usually given only information that is in the public domain. If the two

organizations are mutually dependent and the managements trust each other, they are more outgoing.

Blue Cross Plans can learn more about hospitals' accounts than negotiators in many other fields. One reason is that a great deal of information from both sides is in the public domain, because both are involved in certain governmental payment and regulatory programs. Every hospital caring for Medicare patients on the basis of full cost reimbursement must file a long annual report about costs and operations (form HCFA 2552) with the fiscal intermediary, which is usually the Blue Cross Plan itself. Blue Cross must file a complete financial statement of its own -- membership, income, reserves, and expenses -- whenever it seeks higher premiums from the state insurance commissioner, usually every year.

The friendly relations between the Blue Cross Plan and the local hospitals result in considerable reporting. If a hospital receives prospective reimbursement consisting of last year's costs plus trend factors for prices and utilization, the contract requires submission of a full cost report to Blue Cross, usually a copy of HCFA 2552 (or an equivalent document) plus additional special pages for Blue Cross. The contract allows Blue Cross to send auditors to examine the hospital's books, a right normally absent from a payment system based on bilateral negotiation. (In contrast, Blue Shield and the Medicare fiscal intermediary cannot routinely audit every participating physician's books.)

Not all the Blue Cross Plans have such access. If Blue Cross has few subscribers in a state, a hospital does not want to tip its hand, particularly if it is a proprietary. Foregoing high Blue Cross charges or full cost reimbursement is a low price to pay for secrecy and the freedom to set advantageous charges for all its business. Often the Blue Cross Plan goes along with high charges without extensive financial reporting, since its subscribers want to use that hospital. Even in states with full cost reimbursement and extensive Blue Cross membership, the hospital can avoid the audit by not signing a contract. The patients with Blue Cross policies lose some money, and the hospitals may lose some patients, but the hospital keeps its independence.

Price discrimination. In a private market, each payer negotiates the best deal it can. It tacitly invites the seller to find extra money elsewhere, such as from other payers. In insurance, this creates competitive advantages for the strongest payer, since the others must collect higher premiums or offer lower benefits.

The private insurance companies complain that Blue Cross has used its market power and its special relationship with nonprofit hospitals to gain special advantages, such as discounts, exclusions of certain costs from the calculating base, and selection by most nonprofits as their Medicare fiscal intermediary. When negotiating with an individual hospital, Blue Cross alone has a large enough market share to be taken seriously. Each commercial insurer individually has only a few subscribers in that hospital. HIAA fears that organizing a common negotiating team will be challenged as a violation of the antitrust laws, and it has been unsuccessful in persuading Congress specifically to exempt such arrangements from the antitrust laws. Blue Cross benefits from the status quo and does not wish to join forces with the commercial carriers.<sup>5</sup>

Unable to form a common negotiating team with Blue Cross and with government purchasers, and unable so far to persuade the courts to declare the favorable Blue Cross contracts in violation of the antitrust laws,<sup>6</sup> the commercial carriers have favored state regulatory intervention as a method of putting them on the same footing.<sup>7</sup>

#### EVOLUTION ABROAD

In nearly every other country, sick funds arose independently of the hospitals. A few in Holland and Germany were originated by doctors, to ensure against collection problems, but almost all became independent of all providers and therefore acquired a strong user point of view.

Only England developed any insurance arrangements like Blue Cross. After 1873, many hospitals outside London created "hospital contributory schemes."<sup>8</sup> A program was affiliated with one or a group of hospitals. Subscribers paid regularly and received free care in that

(or any of those) hospital(s) when ill. A scheme was run by the hospital management and therefore was not as independent as Blue Cross. The hospital set its own charges and the contributory premiums. (The concept resembles an American HMO.)

Several countries introduced rate regulation early. For example, the French prefectures set the daily charges for the many publicly owned hospitals even before insured persons used them extensively. Holland introduced price controls over hospitals at about the time membership in insurance funds became common. Until nonprofit and public hospitals began to shift toward full recovery of costs rather than low charges -- due to the impoverishment of their charitable resources during the Depression and war and due to technical advances in medicine -- the hospitals set their own charges. But eventually the sick funds insisted on discussions over the higher charges and over the hospitals' desire to cover all their patient care costs from charges. The discussions were informal and varied in style, as in the United States.

Several countries superseded the negotiations over hospital rates while keeping them for doctors' fees. (Bilateral negotiations between sick funds and medical associations are the typical way to decide the payment of doctors.)<sup>8</sup> Since Swiss cantonal governments paid the difference between the carriers' contributions and total costs, all took over the scrutiny of the hospitals' accounts, approving the hospitals' annual budgets, and setting the sick funds' charges. Every Canadian provincial government has paid its hospital's operating costs in full, and it has decided what to give. The hospitals can petition the province and can appeal, but it does not really negotiate.

#### CURRENT METHODS ABROAD

A complete negotiating system. West Germany is the only major country where all rates of all hospitals are decided by direct negotiations between the sick funds and each hospital. The final rate is announced officially by the Ministry of Health of the government of each province, but the Ministries do not use this nominal authority to exercise regulatory power, wherein they vouch for the accuracy of the

hospital's accounts and for the social justice of the final rates. All money for hospital operating costs comes from the sick funds and none from the provincial governments. (If the provinces paid part, they might take over rate determination, as in Switzerland.) The German sick funds and hospitals are jealous of their right to decide the contractual rules and the pay, so that health insurance and medical care remain their sphere and are not controlled by government. Therefore, the provincial governments proclaim as official the rates agreed upon by the sick funds and hospitals, and they intervene only if the negotiators cannot agree.<sup>9</sup>

German negotiations differ from the American in several ways:

1. The sick funds are independent of the hospitals and clearly represent their subscribers' financial interests. They have driven very hard bargains, particularly before passage of the Hospital Finance Law of 1972 (the Krankenhausfinanzierungsgesetz or KHG). Then the hospitals complained that the sick funds gave so little money that they could not accumulate capital or hire personnel. The law now requires the sick funds to cover the hospital's legitimate costs, but stiff bargaining stances still keep German hospital costs among the lowest of all developed countries'. As a result, the share of all spending going into hospitals is lower in Germany and the proportion going to the office doctors is higher.\*
2. All sick funds unite in negotiating with each hospital. The goal is a daily rate payable by all patients. Even the sick funds who refuse to form a common front against the medical associations -- the Ersatzkassen with middle-class membership -- collaborate in facing the hospitals.
3. The aim always remains the same, viz., to negotiate a daily charge paid directly by sick fund to hospital with no cost-sharing. If the sick funds become financially strapped, they do not switch to charges but give smaller annual increases to the hospitals.

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\*Proportions of all health care spending going into inpatient hospitalization are less than one-third in Germany and between 40 per cent and 60 per cent in other developed countries.<sup>10</sup>

4. The negotiating procedure and the payment system are identical in every German province, despite the possibility of variations inherent in a federal system. The provincial associations of hospitals and sick funds find it advantageous to share experiences and goals through national leaders and common practices.
5. Every negotiation ends in a decision.
  - (a) The hospitals cannot survive financially without an agreement. If a hospital had none, the patients would have to pay so much out-of-pocket that they would go elsewhere. Office doctors would anticipate this reaction by referring patients only to participating hospitals. In contrast, an American hospital not participating in the Blue Cross contract can still prosper, since Blue Cross patients pay only about a quarter out-of-pocket and the other classes of patients are not affected by the impasse.
  - (b) In case of a deadlock, the provincial government always arbitrates. One reason the hospitals try to settle with the sick funds is the province's power to investigate the hospital's books, in order to decide a rate based exactly on its costs.
6. Since World War II, laws and regulations adopted jointly by the national government and by all the provinces have set general principles about the payment of hospitals. They have set the ground rules for negotiation between sick funds and hospitals and for arbitration by provincial governments in case of deadlocks between the negotiators. The most recent law (KHG of 1972) provides the hospitals with major investment money from the national and provincial governments, and replacement money from the sick funds as part of the all-inclusive per diem.

America's Blue Cross can obtain the complete information it needs for deciding on hospital pay because of unintended government requirements, viz., the availability of Medicare cost reports. The fact that German provincial governments officially announce the rates and might need to arbitrate with full knowledge creates the reporting that the German sick funds need. KHG requires the hospitals to fill out retrospective cost reports and prospective budgets (called the

Selbstkostenblätter) and file them with the provincial governments. Since they are in the public domain, the forms are automatically obtained by the sick funds and are the basis for their evaluation of the hospitals' requests. To make sure of the reliability of the Selbstkostenblätter, the hospitals are required to fill them out according to certain accounting conventions (spelled out in the Buchführungsverordnung and the Abgrenzungsverordnung, two regulations implementing KHG), and they keep their books in much the same way.

The German sick funds in all larger communities create a common office (called an Arbeitsgemeinschaft) with a staff that specializes in relations with the hospitals and doctors. The staff examines the hospitals' applications for rate increases and helps the joint negotiating team from all the funds, when it faces each hospital. The Arbeitsgemeinschaft staff resembles the Provider Reimbursement section of a Blue Cross Plan, except that it represents all the carriers and not just one.

The unity among the sick funds and the nationwide rules about reporting and accounting permit the German negotiators to call upon a much larger data base than their Blue Cross counterparts. The national headquarters of the principal association of sick funds (the Bundesverband der Ortskrankenkassen) has revenue sufficient to support a data processing system. It reads in all the Selbstkostenblätter from all the hospitals in the country and sends each provincial Ortskrankenkassen office and each Arbeitsgemeinschaft tables comparing each individual hospital with the averages for all provincial and national hospitals of the same type. The Arbeitsgemeinschaft staff investigates the data from hospitals that are more expensive than their peer group averages and often challenges them during the negotiations. Blue Cross negotiators do the same but have a much smaller data base, restricted to their own region or state.

German negotiators on both sides come armed with similar ammunition. A hospital must be forewarned that it is too high. All the province's hospitals encourage the very cheap ones to spend more, lest the sick funds demand that all come down to the cheapest levels. Every provincial hospital association reads the Selbstkostenblätter into its own data system and generates peer group averages to help each member

in its negotiations. When facing Blue Cross, an American hospital negotiating team lacks such peer group computer output and concentrates on the merits of its own case.\*

In Germany, the statistical information is much alike on both sides of the table, placing limits on the claims and bluffing of the negotiators. The law obligates the sick funds to pay the costs of care in a well-run hospital, so they cannot make unrealistically low counter-offers. Of course, the two sides haggle across the table at the face-to-face meeting: as in all negotiating, the ultimate goal is to agree on one amount of money, the daily charge; the sick fund offers to settle at slightly less than the hospital's request and the hospital asks more; but they are usually close and quickly agree.

Each hospital in Germany has adapted its levels of services, costs, and rate applications to the resources of its locality, and it does not make unrealistic requests. German sick funds are organized with local accounts rather than with unified national accounts that would enable poor areas to bring in money from the rich. Each Arbeitsgemeinschaft consists of representatives of the local sick funds, and they can pay the hospitals only within their means.

Joint negotiating forums. Another vehicle of negotiations might be a standing committee of hospitals, carriers, and the public to discuss and approve rates. A bilateral committee structure with few public representatives was created in 1976 in Michigan between Blue Cross and the state hospital association. The Blue Cross hospital rate-setting committee of Indiana includes some hospital representatives and might evolve in this direction.

Holland's Central Agency for Hospital Charges (the Stichting Centraal Orgaan Ziekenhuistarieven or COZ) is organized in this way, as a joint committee representing the hospitals and sick funds.<sup>11</sup> It can also be interpreted as a public regulatory commission and I described

\*American state regulatory agencies routinely produce such peer group comparisons from their statewide data files, in preparation for evaluation of individual hospitals' applications. States relying on automatic formulae to put down outliers (such as New York) base their system on peer grouping.

it in the previous chapter. The staff acts as neutral experts to investigate the hospital's reports and requests, relieving the two sides of developing their own papers. The full COZ and its committees negotiate the guidelines to the staff. The full COZ usually accepts the staff's judgments about the hospital's cost reports and proposed rates, but it always has the final decision.

Unstructured bargaining. The German and Dutch methods are designed to pay all hospitals. The establishments' financial viability is protected by the law and by the procedures. But an unstructured arrangement is possible -- generous at some times and stingy at others -- as in the case of negotiations between sick funds and proprietary hospitals in France.<sup>12</sup>

While French sick funds are obligated by law to cover the costs of public hospitals, as defined by the regulators in the prefecture, the payment of private hospitals is left to bilateral bargaining between the sick funds and the establishments. (All the nonprofits are now "assimilated into the public service" and receive adequate daily rates from the prefect, leaving only the proprietaries to negotiation.) Since the sick funds are not obligated to cover the proprietaries' costs, and since the proprietaries are unwilling to reveal their records, calculations are not made according to a common set of rules from a cost report, as in the fixing of public hospital rates. Relations between sick funds and the private clinics have always been tense, since the sick funds think the doctors use the clinics to profiteer and underserve. The negotiation by correspondence and by meetings has always been done by the local or regional office of the principal sick fund (nowadays CNAME), and the other funds usually go along. Since the proprietaries will not reveal their costs, they settle on a charge schedule. The results have been generous at some times, strict at others:

1. Until 1968. Local offices of the sick funds negotiated with private clinics. Without guidelines from their national leaders and without full information about the clinics' internal affairs, they gave the proprietaries the benefit of the doubt. The local sick funds were not inhibited by financial responsibility: the revenue was determined by their leaders in Paris. Procedures and generosity varied

across the country. A guideline to limit costs had the unintended effect of increasing them: a decree of the national government said that private hospitals should be paid charges no higher than the daily rate of the nearest comparable public hospital. But the clinics urged the sick funds to classify them like the better and more expensive public hospitals. Besides the daily charge, the clinics increased their revenue from itemized services. The proprietaries grew in number and in income, and they competed successfully for patients with the public hospitals, who were under tighter financial control. The proprietaries' charges were profitable enough to permit them to modernize by self-financing investment.

2. 1968-1973. Strong regional offices were created in the sick funds, and they took over the negotiation with the proprietaries. They were better staffed and had more information than the local offices, but they still lacked verified cost reports from individual proprietaries. And they were still governed by the decree requiring the sick funds to treat a clinic like a nearby public hospital of similar size and function. Private clinics continued to prosper. But public hospitals were now becoming attractive enough for all patients. And the public hospital doctors -- now guaranteed high full-time salaries and limited private practice -- now viewed the private clinic as competitors rather than their part-time workplaces.
3. 1973 to the present. Sick funds and the national government have become very cost-conscious. The national leaderships of the sick funds, in collaboration with the government, send guidelines to their regional negotiators recommending that the annual increases in charges granted to the proprietaries not exceed certain percentages. The clinics' charges and income rise more slowly than those of public hospitals, more slowly than the general inflation rate. Some sick funds grant the proprietaries even less and are upheld on appeal. A proprietary can ask for additional increases, but it must substantiate its case by submitting full reports and accepting auditors' visits, which it usually fears. Even so, the sick fund may refuse an increase. The sick fund is not obligated to respond

within a fixed time, and the papers circulate for months, while the proprietary continues under its old rate. Therefore the proprietaries have been steadily squeezed, perhaps all run deficits under their hospital charges, and they survive only by sharing the fees of their physicians.

#### LESSONS FOR THE UNITED STATES

1. Original unstructured arrangements:
  - (a) Sick funds are at a great disadvantage if they obtain little information from the hospitals. The hospital managers monopolize the expertise. An atmosphere of suspicion spreads.
  - (b) In such situations, sick funds may be generous to hospitals, provided they get money easily from their headquarters or from subscribers. If regulators control their premiums, they may become tough bargainers with hospitals, squeezing many and limiting their investment capabilities. Whether they are generous or stingy, the sick funds act arbitrarily, since they lack accurate information.
  - (c) Sick funds in an unstructured system try to settle with hospitals, rather than drive hard bargains. To attract subscribers, they must be able to offer predictable benefits at a large number of hospitals. If the sick funds' income cannot cover the hospitals' charge schedule in full, at least they can offer an indemnity schedule to subscribers.
  - (d) If every third party tries to negotiate with the hospital individually, the stronger ones drive advantageous bargains with the hospitals and encourage shifting of costs to the weaker. The stronger sick funds and the hospitals collude.
2. Transitions:
  - (a) A negotiation system for charges lacks an end-of-the-year reconciliation and corrections. It is preferred by proprietaries (if they must submit to any negotiation system at all), since they can pocket their profits and avoid explanations. For-profit health insurance companies might accept such arrangements if they can come out ahead.

However, eventually nonprofit third parties try to recapture last year's overpayments, or at least set prospective charges that lack profits. Hospitals try to recover last year's deficits or at least set prospective charges that make up for past charges.

Eventually the parties adopt a compromise position of negotiating over how best to cover the hospital's costs.

- (b) Negotiating in most economic fields is horse-trading over a price that covers personal income as well as costs. When negotiators in hospital finance converge on a formula for covering the hospitals' costs -- no more and no less -- the agenda is very different. The negotiators really are arguing over the hospital's management decisions and utilization plans, requiring expertise often absent from payment negotiations in other fields. The sick funds recommend fewer expensive plans, the hospitals defend them; the sick funds try to detect padding, the hospitals defend their estimates. If full information is provided and the hospitals' prospective budget seems "reasonable," the two sides agree with no dispute, and in practice they often do.
- (c) Sick funds eventually try to form a common front, in order to improve their bargaining power and create a common data base. Even the principal payer joins: gradually complaints by the other funds to government reduce the biggest sick fund's advantages; it eventually decides it can save more money by joining a common front.

### 3. Mature negotiating systems:

- (a) Government is always a key participant in some form, even if the sick funds and hospitals are "privately" owned:
  - (1) Government lays down in law the ground rules for negotiations -- in hospital affairs and in every other important economic sector.
  - (2) In some form, government induces hospitals to produce cost reports that sick funds can examine.
  - (3) Government usually arbitrates deadlocks. The disadvantages

from investigations and awards by government usually induce the sick funds to settle.

- (b) Government is often not a neutral arbitrator or regulator, since it has a financial interest. It may be an important payer (as in American Medicaid) or an important owner of hospitals. The side that might lose from such biased judgments may prefer private arbitration. (For example, the current proposal by German sick funds, in place of arbitration by provincial governments.)
- (c) A negotiating system -- as well as rate regulation -- can be based on a law guaranteeing a hospital its costs of care if performed efficiently. Therefore, the results can be expensive. Unless the sick fund can find manifest weaknesses in a hospital's retrospective expenditure reports and prospective budget, it must go along. A common method for sick funds is peer group comparisons by computer. Outlyers are suspected of exceeding the statute's definitions, but it is difficult to make a case that the entire class is inefficient and wasteful.
- (d) Sick funds must develop a considerable staff to analyze the hospitals' financial reports and challenge the past work and future plans of one establishment's financial manager and chief medical officer. The costs of a staff and computer center are motives for collaboration among the sick funds.
- (e) If the hospital association and sick funds create a joint investigating and mediation committee -- e.g., COZ in Holland or some joint hospital-Blue committees in the United States -- the body can perform the functions of a regulatory agency. But the joint committee will be more generous and less intrusive than a regulatory agency, as the experience of COZ shows.
- (f) Hospitals are under less pressure to settle if:
  - (1) Government cannot arbitrate.
  - (2) The absence of a contract merely inconveniences the patient rather than excludes all direct or indirect payment to the hospital by the sick fund. For example,

American hospitals can gamble by refusing to sign with Blue Cross, since the patient retains partial coverage and collects reimbursement from the carrier.

## FOOTNOTES

1. The history of Blue Cross is in Odin Anderson, Blue Cross Since 1929 (Cambridge: Ballinger Publishing Company, 1975).
2. The philosophy appears in Robert M. Sigmond and Thomas Kinser, The Hospital-Blue Cross Plan Relationship (Chicago: Blue Cross Association, 1976), pp. 40-42.
3. John Diffenbach and Katharine G. Bauer, "The Philadelphia Blue Cross 1971 Contract Negotiations" (Boston: Intercollegiate Case Clearing House #9-373-126, 1972).
4. Mina Hoover and Robert P. Mullen, "Blue Cross Contract Provisions: July 1, 1979" (Chicago: Division of Financial Management, American Hospital Association, 1979).
5. Hospital Cost Containment Act of 1977 (Washington: Hearings before the Subcommittee on Health and Scientific Research of the Committee on Human Resources, United States Senate, 95th Congress 1st Session, 1977), Part 1, pp. 616-624. These pages transcribe a panel discussion between representatives of HIAA and Blue Cross. The strong advocates of competitive solutions seem opposed to common negotiating teams as monopsonistic. For example, Clark C. Havighurst, "Role of Competition in Cost Containment," in Warren Greenberg (editor), Competition in the Health Care Sector (Washington: Federal Trade Commission, 1978), pp. 391-393.
6. Travelers Insurance Company v. Blue Cross of Western Pennsylvania, 361 F. Supp. 774 (1972). No violation was found in the advantages accruing to participating hospitals who agreed to Blue Cross' terms and in the disadvantages for those who refused to agree to the contracts. Frankford Hospital v. Blue Cross of Greater Philadelphia, 417 F. Supp. 1104 (1976).
7. "Hospital Cost Control -- The State Option" and "Hospital Cost Control -- The State Option Revisited," in Viewpoint (of the Health Insurance Association of America), March 1978 and January 1980.
8. Described in William Glaser, Health Insurance Bargaining (New York: Gardner Press and John Wiley, 1978).

9. A summary of the payment method is Maria Gehrt and Heiko Jüngkerkes, Selbstkostenrechnung nach der Bundespflegesatzverordnung (Stuttgart: Verlag W. Kohlhammer, Third edition, 1982). The national laws and regulations are in Karl Jung and Marianne Preuss, Rechnungs- und Buchführung im Krankenhaus (Stuttgart: Verlag W. Kohlhammer, 1978).

10. Robert J. Maxwell, Health and Wealth (Lexington, Mass.: Lexington Books, 1981), pp. 82-83.

11. Described in William Glaser, Paying the Hospital in The Netherlands.

12. Glaser, Paying the Hospital in France, Ch. IX.



## CHAPTER VIII

### GLOBAL BUDGETING

#### ISSUE

Some critics of modern hospital reimbursement -- particularly governmental finance officers -- have proposed global budgeting. It is designed to make hospital expenditure predictable and controllable. At the start of the fiscal year, each hospital would be given a fixed sum, viz., last year's budget plus an improvement factor. Each hospital would be expected to live within its budget. Instead of the constant nibbling and over-runs from the disparate activities of doctors and managers, the decisions about total hospital spending would be made by planners and national budget makers, in the light of the larger national budget and taxes.

Some favor making the individual hospital's budget a share of a larger global total for the country's entire hospital sector. Each hospital's share might be calculated according to expected utilization. Perhaps utilization itself might be limited to a maximum amount, thus firmly limiting expenditure.

Proposals for global budgeting are designed to limit the annual increase in the share of a country's resources going into hospital care. They resemble proposals to restrict the share of a country's resources going into government,<sup>1</sup> but the ceiling on hospital spending includes the private sector too. The annual improvement factor in hospital spending would be tied to the annual growth in GNP or growth in the yield from taxes. Lest the hospitals' clinical progress be halted, the hospitals' spokesmen argue that any global budgeting guarantee certain increments for technology and clinical programs each year, no lower than costs of clinical practice. If global budgeting is a temporary emergency, the spokesmen for hospitals try to protect the hospitals' resources and

cash position by insisting that the improvement factor equal the rate of inflation for the services and products bought by hospitals. Payers argue that the improvement factor should be calculated from their own ability to pay for all health services.

Proponents recommend considerable discretion for hospital managers in reallocating resources and in offering services to the public. Since both increased utilization and increased costs would have to be covered by the improvement factor, managers would have to make several tradeoffs. They could no longer argue to grantors or rate regulators that they need greater amounts of everything.

Managers and doctors would be required to work within their budgets, without the end-of-the-year retroactive increases that always occur under cost-reimbursement methods. Managers and doctors would think about the total figure, not the daily rate or charges for services, as they do in most countries. At present, in rate reimbursement systems, the regulators and negotiators approve a prospective total budget for each hospital. Rate setters then take a next step of dividing the globe by expected number of patient-days, and thereafter the hospital is paid by multiplying the daily rate by each patient's stay and (sometimes) by adding special charges. Hospital costs can drift upward through more utilization. But supposedly a manager under a global budget must control or reduce utilization.

#### AMERICAN EXPERIENCE

Government. In the United States, government agencies operate each year under budgets fixed in advance. In practice, cost over-runs occur for many, and they seek deficiency appropriations from the legislature, or the chief executive and Treasury come to their rescue by borrowing. Usually they have not come to the legislature with simple global budgets, but they have had to estimate the costs of their component programs.

Entire hospitals are financed in this way if they are owned by national and state governments in the United States. But they are

exceptional. Most give long-term rather than acute care.\* (One-third of the short-term community hospitals are owned by state and local governments, but they are not paid by global budgets. They charge third-parties and patients, like any nonprofit and proprietary, but they also receive subsidies from the state and local governments.)<sup>3</sup>

The impetus for global budgeting comes from government, which needs to make its activity predictable, to avoid deficiency appropriations and borrowing, and to prevent one sector from consuming resources too fast at the expense of other sectors. The hospitals of the Veterans Administration -- 171 medical and psychiatric establishments totalling 7 per cent of the country's inpatient capacity -- are funded completely by the national government according to global budgetting. Congress gives the Veterans Administration an annual total budget, with part designated for health care. The VA's Central Office distributes the total among the hospitals according to their inpatient load, outpatient load, and specialized medical programs. Each director must submit a prospective budget to the Central Office each year but then has considerable discretion in expenditure.<sup>4</sup> No extensive studies have been done of the economics and management of the VA hospitals, but they would provide an instructive experience of global budgeting in America's highly politicized and undisciplined system.

The VA hospital doctors are sufficiently influential politically that their salaries are not included in the globe. Like hospital consultants in Great Britain, they are guaranteed full payment according to a salary scale.\*\*

\*Of the 6,988 hospitals registered in the United States during 1979, 361 were owned by the national government, 299 were psychiatric and respiratory hospitals owned by state or local governments.<sup>2</sup>

\*\*At times their salaries are frozen, and at other times large increases are enacted by Congress, particularly during election years. Congressmen try to satisfy the doctors' complaints that they are falling too far behind the private physicians. When Jimmy Carter vetoed an increase, on the grounds it violated his attempts to restrain all health care costs, Congress overrode his veto (on 26 August 1980) by one of the largest margins in American history (85-0 in the Senate, the first unanimous over-ride since 1905; and 401-5 in the House). No other

(continued on following page)

Public general hospitals in the United States have always had mixed financing for patient services, along with subsidies from local and state governments. The proliferation of new financing arrangements for the poor using per diems for each individual case -- i.e., Medicare and Medicaid -- has increased the mix. As financial management for both hospitals and local governments became more orderly during the 1970's, it looked as if many individual hospitals might be evolving toward global budgeting. In such cases, a parent agency in government calculates the hospital's total budget and pays it in installments; the agency collects all the third party charges for individuals; and the agency balances its books by means of the appropriations from the city council or state legislature.

Whether any community hospital can operate according to global budgeting in the turbulent setting of the United States is unknown. The public general hospitals were chief victims of the chaos in the American cities during the 1970's. In order to avoid bankruptcy, city governments made sudden and large cuts in their hospital appropriations. After political uproars, appropriations were suddenly increased or shuffled among lines in budgets. Meanwhile, the poor increased in number (through births and immigration) and in their utilization (particularly of the OPD and emergency services). Public general hospitals were not allowed to operate according to the theory of global budgeting: the city and state governments did not increase appropriations automatically to cover all utilization; the hospital managers usually were not allowed (because of political pressures) to reduce services or shut down completely.<sup>5</sup>

Voluntary and proprietary hospitals. Global budgeting is an instrument of superior power by a single outside agency. In no country do privately owned hospitals like such arrangements, particularly if they will be administered strictly. They cling to the billing of individual patients according to costs or charges. Because of their rivalries and different methods, American payers do not join in a common negotiating front and in a pooled paying agency. If the third parties tried to unite, American hospitals would file antitrust suits.

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national legislature gets so deeply involved in the payment of doctors. It is one of the many devices enabling American Congressmen to claim political credit.

Only a state regulatory agency could provide such central direction under present American conditions. Weary from struggles with elusive hospital financial managers over conventional rate structures and eager for a method that combines financial restraint without regulatory intervention into management details, the Health Services Cost Review Commission of Maryland has devised an experiment in a form of global budgetting fitted to the American situation. Its Guaranteed Inpatient Revenue system (GIR) assures the hospital of a particular total sum for the coming year. The total is the product of the average cost per case (defined from DRG's) for each payer times the hospital's expected admissions. Adjustments are made at the end of the year, correcting for changes from the predictions in case mix, number of admissions, and inflation.<sup>6</sup> The method differs from pure global budgetting in several ways: in accordance with American practice, distinctions are made among payers' liability per type of case; the hospital bills the payers individually and by case instead of receiving aggregate installments from a pool, and the aggregation occurs only in the start-of-the-year and end-of-the-year calculations; generous retrospective adjustments are made; the hospitals in practice are assured of at least their revenue from rates, or they would not cooperate. However, hospitals are able to keep part of their savings and must bear part of their over-runs. Statistics from Maryland show that the participants so far have restrained numbers of patient-days and of ancillary services.

Global budgeting for an individual payer: Medicaid. Unable to impose strict global budgeting over entire hospitals, some state governments try to cap Medicaid, which has been a mounting and unpredictable drain on state government appropriations. Deviating from the statutory Medicare-type cost reimbursement has required a waiver from the Department of Health and Human Services. Massachusetts obtained a waiver in 1974, permitting it to pay acute hospitals by charges rather than by cost-reimbursement. A Rate Setting Commission was created to review the hospitals' applications for cost-based rates and Medicaid charges. For several years, it advised the Department of Public Welfare (DPW) about the charges needed to pay for the expected Medicaid caseload and costs.<sup>7</sup> The Governor would then ask the legislature to appropriate the required

total, as part of the DPW's annual budget. By the late 1970's, the financial crisis of the state showed the draconian potentialities of global budgeting: the state indicated what it could afford, the acute hospitals told what they needed, and the commission set charges close to the financial capacity of the state. The hospitals complained they lost too much money on their Medicaid patients (12 to 15 per cent of the total) and had to transfer too many costs to the self-payers (10 to 15 per cent of the total). The hospitals were saved from immediate bankruptcy because this strict global budgeting applied only to the Medicaid share and not to all revenue; but the Massachusetts Hospital Association predicted a steady decline, because of the lidding of Medicaid, the incomplete contractual allowances of Medicare and Blue Cross, and the scarcity of self-payers who could be over-charged.<sup>8</sup>

While Medicaid only pays a share of acute hospitals, it is the principal payer -- and sometimes almost the complete financial source -- of nursing homes. Attempts by a state to cap its total Medicaid spending usually lead to capping the spending on nursing homes. One solution might be true global budgeting, i.e., a contract with each nursing home to provide certain services for a total annual sum. But American health reimbursement is locked into daily rates and item-of-services payments, supposedly helping the patient pay his bills.\* The nursing home experience under Medicaid shows that the method is not only difficult to control in budget terms but prevents the payer from bargaining with the establishment over the content and quality of his services.

Global budgeting for an individual payer: Blue Cross. Capping Medicaid is fixing a lump sum, not globalizing and lidding the entire hospital. The hospital finance officers then try to cover their costs from other payers.

Several Blue Cross Plans using cost reimbursement offer the option of lump sum payments. After the negotiators agree on the total hospital budget and the Blue Cross share, they do not convert the Blue

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\*Some state governments struggled to cap Medicaid costs by convoluted formulae for per diem payments. The formulae not only had to achieve their financial objectives but also to withstand the characteristic American barrage of lawsuits, since the national law had recently been changed to extend cost reimbursement to nursing homes.<sup>9</sup>

Cross share into a daily rate. Bills are not set for each case, as a multiple of the per diem times the stay. Rather, the predicted Blue Cross share is paid in equal lump sum installments to the hospital, every two weeks or more often. Blue Cross is obligated to pay costs in full in those states, and retroactive additions are made on the basis of the annual report about costs. Therefore, no lid exists. The financial outcome is exactly as if per diem billings were used. Otherwise no hospital would participate. Therefore, Blue Cross saves no money for patient care, only a little for administration.

An advantage for the hospital is a steady flow of cash, without the seasonal fluctuations from patient billings. Unlike the lump sum arrangements for Medicaid, Blue Cross pays in full through end-of-the-year adjustments, and therefore the hospitals don't have to search elsewhere to meet shortfalls. Nevertheless, the introduction of lump sum methods raises spectres of controls and lids, and few hospitals agree to them. If one third party paid lump sums, other payers might join; hospital managers prefer multiple payers and fear monopsonists, particularly when government leads the coalition.

#### EVOLUTION ABROAD

As hospitals have become more expensive and have strained the taxes for national health insurance, finance officers of governments and weary rate regulators have begun to propose global budgeting for the hospital sector, like the annual fixed appropriations for each government department. But, as in the American states with rate regulation, the method is beyond their control: the hospitals are privately or locally owned; they are paid by the patient-day; the NHI statute guarantees reimbursement of their costs; the doctors and hospital managers have the initiative in defining the hospital's needs and costs.

Government expenditure. When nonprofit private carriers are unable to implement national health insurance, government steps in. It pays for the operating costs of hospitals almost entirely from general revenue, and all citizens are entitled to use them, usually without cost-sharing. Often the same tier of government that pays for hospital care

takes over ownership and management. Examples are Great Britain, Sweden, the USSR, several Eastern European countries and most underdeveloped countries. Management and financing of hospitals are part of the legislation and annual budgets of that unit of government, like any other public service.

In a few countries, the payment of hospitals is part of government's budget but the ownership and management rest in the same hands as before. Only a few hospitals are owned and managed by the government that pays them. Examples are Canada and (under its new NHS legislation) Italy. (In Canada, all hospital operations are paid by each provincial government, but hospitals are owned entirely by voluntary associations in several provinces and by a mosaic of voluntary associations and local governments elsewhere. In Italy, the hospitals will be paid by a flow of money from national social security funds to the regional governments; but hospitals will be owned by local units under the regions, by religious associations, by universities, and by physicians.)

In companion volumes to this monograph, I have described the financing and administration in the principal examples of the two types, viz., Great Britain and Canada.<sup>10</sup> They contain the details about how government decides the total available to the entire hospital sector and then divides it among installations. Following are some conclusions based on those countries and my partial knowledge of others.

1. At first, hospital managers submit prospective proposals to higher-ups, as they do in rate regulation and in rate negotiation. They assume that the Government should supply them with the money they need. The many ambitious requests total far more than government can afford without damaging competing programs, so eventually higher officials decide the total and distribute it to the hospitals, either directly or via intermediate administrative tiers. The payers may no longer ask the hospitals to submit prospective budgets and requests, but may merely distribute the available money by a formula.<sup>11</sup> Top-down budgeting replaces bottoms-up budgeting.
2. Global budgeting can be generous or stingy, depending on public policy. Therefore, hospitals can absorb much of the national income (as in Sweden) or little (as in the USSR and Britain). A public

budgeting system requires formulation of a policy, while other methods of paying hospitals do not. Instead of being an uncontrolled entitlement, health must become part of the government's larger policies. If these policies include reducing the share of the public sector in the GNP or fighting inflation, the restrictions are applied loosely to the entire health sector.

3. To be an effective and predictable control over expenditures, a ceiling over money must be accompanied by a ceiling over utilization. But then the planners must decide how to provide for the excess demand: outright refusals, rationing by valuational criteria, queuing by time of application, or encouraging an outside free market.
4. Whether a hospital stays within limits depends on its political support and the status of the managers. It can spend more than its budget if it is privately owned and strongly supported in the community. If the hospital is owned by the paying government, the manager cooperates, lest his career be damaged. Higher-ups in government prefer the hospital to underspend rather than provide more or better services within the allotted money. Compared to their public counterpart, managers of privately owned hospitals argue more over the initial grant.
5. Very few doctors participate in the big decisions about totals for the country's hospitals. A powerful force is the Treasury; whose economists are skeptical of health services, because the latter are labor-intensive and show no improvements in productivity. The Treasury discourages end-of-the-year settlements with hospitals to pay cost over-runs, lest all government agencies come to them for large deficiency appropriations. Hospitals are usually forced to operate within the prospective budgets, but not always.
6. A combination of ownership and financing by the same government agency can bring about closings and replacement of hospitals -- to be sure, not without community protests. But financial power alone will not force closings, if the owners and managers are independent and lead the community's protests.
7. Since everything revolves around a single payer's resources and

decisions, it may attract great political pressures. If orderly channels of consultation and explanation are constructed between government and the interest groups, and if all interest groups are apprised of the conflicting demands, then much of the political heat is reduced. With such consultation machinery, fewer end runs to the legislature for special treatment will result.

8. One might expect hospitals to compete with each other over money. But the allocation can be made non-political by formulae, to decide which localities or establishments get more of the money. Writing the formulae might involve political struggles at a higher level of the government, beyond the hospitals' managers.
9. A combination of ownership and financing by the same government agency can bring about a division of labor and coordination among hospitals. Intelligent leadership by the payer can accomplish some of this, even if the hospitals remain independent. Each hospital must use its available money to concentrate on certain specialties. All occupy the same situation vis-a-vis the single payer. The payer considers them all, tries to get the greatest mileage from its money, and advises their managers.
10. Hospital wages tend to follow those in the rest of the economy, even if they are not formally linked to the civil service. As new technology and new subspecialties are added to the hospital, the labor force expands. Therefore, hospital costs rise under global budgeting as well as under other forms of payment.
11. Cost increases resulting from utilization can be restrained under global budgeting, if managers and doctors must live within their budgets. This may be achieved through supply constraint. Patients may complain about queues, but costs will be controlled.
12. Hospital managers never get as much discretion as they expect. Public money (from either government or sick funds) is never handed over to private establishments (or even those owned by local governments) without an accounting afterward. Detailed line-by-line financial reports enable the payer to judge whether the hospital was wasteful or whether it underserved. Even if the next financial lump sum is given on the basis of a very general prospective budget, the

payers grant it in the light of the last expenditure report and assume that the operations will follow projections from the lines. Government and the sick funds have policy priorities in the hospital sector, send exhortations or grant conditions to the hospitals, and scrutinize the hospitals' detailed expenditure and statistical reports to make sure that their wishes are heeded.

13. Hospital managers are not allowed to keep any unspent money and use it at their discretion. Governments and sick funds believe that unused public money should revert to its owner. Hospitals at best can share in savings, under very carefully defined arrangements.
14. Global budgeting simplifies reporting and accounting. The hospital need not report costs by service, by type of patient, or by payer. It need not calculate costs by source; cost-center accounting (i.e., stepdowns) is not done. Very little is known about the internal finances of the country's hospitals, and certain forms of cross-national statistical comparisons are impossible.
15. In practice, global budgeting is not so different from other methods of paying and monitoring hospitals. The differences are:
  - (a) At the end of the year, hospitals are less likely to be paid extra money for cost over-runs.
  - (b) Receipts are more predictable each year. Receipts do not increase or decrease because of unexpected changes in number of patient-days. Such changes in utilization usually do not change this year's revenue through end-of-the-year adjustments but affect next year's global grant.
  - (c) Accounting and reporting are less detailed.
  - (d) Even if they are privately or locally owned, the hospitals more often enter into planned divisions of labor.

The effects of any payment system depend on how it is administered. Global budgeting has been as generous as rate regulation in some countries at some times, much stricter in expenditure control under other conditions. Therefore, the mere existence of global budgeting or rate regulation or any other arrangement on a national scale -- i.e., merely including them as dummy variables in equations -- does not produce an invariant result.

Some comparative data are in Table VIII-1. Canada and the United Kingdom have global budgeting, France has a mixture of rate regulation (for the public hospitals) and negotiation (for the private hospitals), and the United States has a little of everything. The table includes the entire hospital sector, and not the acute short-term alone. In all countries, the costs of the acute hospitals have risen faster than the costs of other hospitals.

Costs have risen in the National Health Service of Britain consistently less than in the others. Spending was more generous in all countries during the 1960's; it was slightly more even in Britain. All tightened up through their several methods during the 1970's, particularly during the late 1970's.

When a country has global budgeting, it is more consistent. Expenditures follow the inflation rate -- which no government can easily control -- but the ratio of hospital expenditure growth to general inflation can be controlled somewhat under global budgeting. Canada increased hospital spending much faster than the CPI during the optimistic 1960's, brought it down during the 1970's relative to the CPI, and seems now to be keeping it at the inflation rate. Despite the country's buffeting by inflation during the 1970's, Britain has kept hospital spending close to the CPI since the late 1960's. The United States should have had an easier task in economic management, since its inflation rate is lower than most others, but during the 1970's, its less structured hospital spending usually rose more than Canada's and Britain's.

The countries with nonbudgetary payment methods fluctuate more from year to year, since they lack a central controller with a long-term policy. The United States has fluctuated in ratio of hospital spending to general spending, even though its bursts of inflation have been less extreme than other countries'. Its pattern reflects its stop-and-go economic policies. The restraints of ESP brought the relative increases down from 1973 through 1975; the combination of the Voluntary Effort and state rate regulation made a difference in 1978 and 1979.

The budgetary restraints have kept total health spending in close relationship to GNP in both Canada and Britain. The proportions

Table VIII-1  
Increase in Spending for Hospitals

|                | Canada                                  |                 |   | United Kingdom, NIS alone               |   |                 | France                                  |                 |   | United States                           |   |                 |
|----------------|---|-----------------|---|---|---|-----------------|---|-----------------|---|---|---|-----------------|
|                | Increase in all hospital spending, in % |                 | Relative to CPI                         | Increase in all hospital spending, in % |   | Relative to CPI | Increase in all hospital spending, in % |                 | Relative to CPI                         | Increase in all hospital spending, in % |   | Relative to CPI |
|                | Increase in all hospital spending, in % | Relative to CPI | Increase in all hospital spending, in % | Relative to CPI                         | Increase in all hospital spending, in % | Relative to CPI | Increase in all hospital spending, in % | Relative to CPI | Increase in all hospital spending, in % | Relative to CPI                         | Increase in all hospital spending, in % | Relative to CPI |
| 1965           | 12.7                                    | 5.3             | 9.9                                     | 2.1                                     | 11.0                                    | 4.4             | 9.3                                     | 4.4             | 9.3                                     | 5.5                                     | 9.3                                     | 5.5             |
| 1966           | 14.3                                    | 3.9             | 10.4                                    | 2.7                                     | 10.1                                    | 3.7             | 12.8                                    | 4.4             | 12.8                                    | 4.4                                     | 12.8                                    | 4.4             |
| 1967           | 14.7                                    | 4.1             | 9.6                                     | 3.8                                     | 9.2                                     | 3.4             | 16.5                                    | 5.9             | 16.5                                    | 5.9                                     | 16.5                                    | 5.9             |
| 1968           | 15.8                                    | 4.0             | 9.2                                     | 2.0                                     | 17.0                                    | 1.6             | 15.2                                    | 3.6             | 15.2                                    | 3.6                                     | 15.2                                    | 3.6             |
| 1969           | 12.7                                    | 2.8             | 10.6                                    | 2.0                                     | 26.1                                    | 4.1             | 14.3                                    | 2.6             | 14.3                                    | 2.6                                     | 14.3                                    | 2.6             |
| 1970           | 13.0                                    | 3.9             | 15.4                                    | 2.4                                     | 15.9                                    | 3.1             | 15.7                                    | 2.7             | 15.7                                    | 2.7                                     | 15.7                                    | 2.7             |
| 1971           | 12.0                                    | 4.1             | 16.0                                    | 1.7                                     | 16.6                                    | 3.0             | 10.7                                    | 2.5             | 10.7                                    | 2.5                                     | 10.7                                    | 2.5             |
| 1972           | 9.7                                     | 2.0             | 16.5                                    | 2.3                                     | 14.9                                    | 2.4             | 13.7                                    | 4.2             | 13.7                                    | 4.2                                     | 13.7                                    | 4.2             |
| 1973           | 12.5                                    | 1.6             | 13.7                                    | 1.5                                     | 14.9                                    | 2.0             | 10.6                                    | 1.7             | 10.6                                    | 1.7                                     | 10.6                                    | 1.7             |
| 1974           | 20.6                                    | 1.9             | 28.4                                    | 1.8                                     | 22.1                                    | 1.6             | 15.8                                    | 1.4             | 15.8                                    | 1.4                                     | 15.8                                    | 1.4             |
| 1975           | 23.7                                    | 2.2             | 26.5                                    | 1.1                                     | 30.9                                    | 2.6             | 16.5                                    | 1.8             | 16.5                                    | 1.8                                     | 16.5                                    | 1.8             |
| 1976           | 13.2                                    | 1.8             | 15.8                                    | 1.0                                     | 25.9                                    | 2.7             | 14.7                                    | 2.5             | 14.7                                    | 2.5                                     | 14.7                                    | 2.5             |
| 1977           | 4.1                                     | 0.5             | 10.4                                    | 0.7                                     | 16.4                                    | 1.7             | 13.2                                    | 2.0             | 13.2                                    | 2.0                                     | 13.2                                    | 2.0             |
| 1978           | 6.8                                     | 0.8             | 12.9                                    | 1.6                                     | 18.7                                    | 2.1             | 12.0                                    | 1.6             | 12.0                                    | 1.6                                     | 12.0                                    | 1.6             |
| 1979           | 10.9                                    | 1.2             | 18.1                                    | 1.4                                     | 18.7                                    | 1.7             | 13.0                                    | 1.2             | 13.0                                    | 1.2                                     | 13.0                                    | 1.2             |
| 1980           |   |                 | 31.3                                    | 1.7                                     | 19.2                                    | 1.4             | 16.2                                    | 1.2             | 16.2                                    | 1.2                                     | 16.2                                    | 1.2             |
| Annual Average | 13.1                                    | 2.7             | 15.9                                    | 1.9                                     | 17.4                                    | 2.6             | 13.8                                    | 2.8             | 13.8                                    | 2.8                                     | 13.8                                    | 2.8             |

My calculations from several sources.

Canada: unpublished data from the Institutional Statistics Section, Health Division, Statistics Canada. Similar to entries in Hospital Statistics (Ottawa: Statistics Canada, annual).

United Kingdom: Unpublished data from the Department of Health and Social Security, supplied to me by the Office of Health Economics, London.

France: Méthodes et séries 1950-1977 (Paris: INSEE and GREDOC, 1979), p. 50; and O. Cesari, Les dépenses de santé de 1979 à 1980 (Paris: GREDOC, 1981), pp. 113-14.

United States: Mark S. Freedland, "National Health Expenditures," Short-Term Outlook and Long-Term Projections, "Health Care Financing Review," Volume 2, Number 3 (Winter 1981), p. 119; and Robert M. Gibson and Daniel R. Waldo, "National Health Expenditures, 1980," Health Care Financing Review, Volume 3, Number 1 (September 1981), pp. 32 and 34.

gradually drift upward in other countries.<sup>12</sup>

Proportion of GNP going to health

|      | <u>Canada</u> | <u>United Kingdom</u> | <u>France</u> | <u>United States</u> |
|------|---------------|-----------------------|---------------|----------------------|
| 1975 | 7.1           | 5.71                  | 7.9           | 8.6                  |
| 1976 |               | 5.72                  |               |                      |
| 1977 | 7.1           | 5.78                  | 7.9           | 8.9                  |
| 1978 |               | 5.71                  | 8.2           | 8.9                  |
| 1979 |               |                       | 8.4           | 9.0                  |

When the leading government officials decide the amounts of money to be spent on hospitals and health, they do not tie it closely to GNP. The latter figure is too elusive; estimates will not be available until a few years later. Rather the health spending is tied to government's revenue from taxation. Restraint is designed to minimize government deficits. If restraint is strict, the relationship to general economic indicators is nearly constant.

Global budgets with several contributors. Under global budgeting, usually one payer sends all the money to each hospital directly. But multiple payers can combine through a central agency. An example is the Centrales d'encaissement of French-speaking Switzerland, described on pages V-11 and V-12, supra.<sup>13</sup> The hospital's detailed budget for the next year -- filled out according to the usual Swiss formats -- is examined by the staff of the Centrale in the usual detailed way, and it is approved by the Commission. In the rest of Switzerland, the hospitals then collect revenue by sending bills to sick funds for individual patients, calculated by multiplying their daily rate times the number of days. In addition, they receive annual installments from the cantonal governments.

The Centrale pools all the money. It gets lists of patients, their sick funds, and their lengths of stay. Each hospital has its own per diem. The Centrale bills each sick fund for all care given its patients that week (more or less) by multiplying total days by the per diems of the various hospitals. The Centrale then sends each hospital the total lump sum in its agreed budget in weekly or biweekly installments. The cantonal government gives the Centrale its total subsidy

for all hospitals, and the Centrale distributes it every week or two. At the end of the year, the hospital should get more or less money according to its utilization, and the Centrale administers the reconciliation of each sick fund's account with each hospital. Global budgeting therefore is used as an administrative convenience at present, but the Centrale could impose stronger financial discipline and controls if the Commission wished.

A pooling of money occurs in the calculations for a current experiment in financing several dozen French hospitals, called "budget global."<sup>14</sup> As in Switzerland, a detailed budget of expected utilization and costs is written by the hospital at the start of the year. In the usual French way, it is examined and approved by the health regulators in the prefecture, the DDASS. The problem then is how to divide the total into lump sums and assign it to the several sick funds. The Swiss Centrales divide the totals by the expected number of patient-days for each third party. Since policy-makers in the French national government and hospital association are trying to reduce costs by reducing the number of patient-days, they distribute the total budget among sick funds according to their number of admissions during the last reported year. For example, if one fund had 68 per cent of the admissions, its lump sum for the next year will be 68 per cent of the approved budget. Each sick fund pays each hospital directly in regular installments, relieving itself and the hospital of large billing costs. If the distribution of patients changes, transfers among sick funds are not made at the end of the year, but corrections in the flow of money are automatically made in the future. At the end of the year, each hospital's losses or profits are reviewed by the DDASS, and they are added to or subtracted from the liabilities of the sick funds next year.

During the first years of the French experiment, hospital managers wrote better budgets, since the year's cash situation depended on them and since corrections of miscalculations were uncertain. Compared to earlier practices, hospitals learned to live within the limits. Since revenue did not depend on the patient-day, the hospital's management did not become anxious over shorter stays. Administrative work was saved. Hospitals and sick funds could predict their cash flow, and

hospitals did not have short-term cash crises. Lump sum payments by sick funds proved difficult to reconcile with a tradition of patient cost-sharing by coinsurance, which presumes a percentage of each patient-day.

Strict global budgeting of all providers. Some advocates of global budgeting hope to impose it upon the entire health sector, including the doctors. A fixed sum would be established at the start of the year, sufficient for an adequate level of services; doctors and others would be expected to work within it, becoming more efficient if demand exceeds predictions. Doctors might be paid under flat rates that fit the globe, such as salary or capitation.

Global budgeting in the payment of providers once existed for doctors in Germany. During the early twentieth century, several sick funds had contracts with lists of ambulatory doctors and gave them all an annual lump sum (the Kopfpauschale), which the doctors divided among them. The method resembled some American Individual Practice Associations. In 1932 the method was generalized in Germany. All doctors admitted to insurance practice in a province formed an association, the Kassenärztliche Vereinigung. All sick funds gave their predicted annual payments for ambulatory care to the KV, which then divided it among the members according to items of service, priced by a relative values scale. All ambulatory care in the province had to be paid for within the lump sum; if doctors submitted more bills than expected, each fee was depressed lower than predicted. The individual doctors once favored the system, because they dealt only with their own KV management and were spared the once bitter struggles with the sick funds.<sup>15</sup>

The global budget had been devised by the sick funds and worked to their advantage. It limited the incomes of doctors and pressed each to work rapidly and for long hours. The competition among doctors was cut-throat: many performed many itemized acts at breakneck speed and some wrote false bills, so they could collect larger shares of the fixed amount. The KV's had been handed a poisoned apple: their leaders had to distribute all the money and hear the doctors' complaints; they had to investigate apparent over-prescribers, reduce fees, and ban from panel practice those submitting false claims.

Germany was able to keep health care costs very low until the late 1960's. The participating office doctors in a province were expected to perform all their ambulatory work within the Kopfpauschale. The sick funds and KV bargained over the total, and the sick funds got away with low payments. The sick funds also drove very hard bargains with hospitals, limiting personnel costs and providing very little investment money.

The individual doctors had always campaigned for fee-for-service and guaranteed payment according to a schedule of charges. The KV leaderships wanted to be rid of the thankless job of enforcing the sick funds' financial controls over the medical profession. During the 1960's, the doctors persuaded the Christian Democratic government and the sick funds to repeal the global budget and guarantee payment in full of each act on the fee schedule. The KV's survive as a vestige of the past, processing bills as the sick funds themselves do in other countries and insulating the doctors from close scrutiny. Since the change, doctors have prospered and costs in German ambulatory health care have risen.<sup>16</sup>

Health care providers therefore will not voluntarily accept global budgets merely because reformers think the method will control costs. Providers want payment guarantees for their costs and incomes, as they define them. Medical associations and hospital associations do not want to allocate lump sums among their members. At most, they will agree to systematic negotiated restraint on fees and charges, connecting them with some larger economic parameters but with frequent review of the results.<sup>17</sup>

#### LESSONS FOR THE UNITED STATES

How a global budget system or any method of ceilings works depends on how it is administered.<sup>18</sup> It can be generous or stingy, depending on the country's priorities and configuration of political pressures. Increases in the global budgets can be tied to movements in large economic indicators, but that is a potentially controversial political decision requiring review.

Global budgeting might start with provider applications, as in any other payment system. But, in times of stringency, it may switch to top-down allocation of funds. This shifts power to finance officers of governments who are outside of health and skeptical of health services.

To be effective as a method of containing cost, global budgeting may involve ceilings on utilization and not just on money. Leaders must then decide how to handle unmet demands.

Global budgeting is opposed by crucial groups who may prevent its adoption, terminate its existence, or weaken its operations:

1. Doctors and other providers. If the globe is strictly enforced, they must work harder, have limits on their resources and income. They can fight off controls sometimes -- but not always successfully -- if ownership remains private.
2. Leaders of the associations of providers. They don't want the job of performing allocation tasks for the payers, the job of underpaying or disciplining some of their members.

Hospitals may or may not be forced to live within their prospective budgets.

1. If the country has financial difficulties, there may be no deficiency appropriations or end-of-the-year corrections.
2. If the policy-makers are more permissive, there can be end-of-the-year settlements. This is particularly true if other hospitals are using other methods, since they usually involve cost reimbursement. Then global budgeting is only a demonstration project, not a national program, and the hospitals refuse to cooperate unless they are guaranteed the same revenue as before. Under such conditions, global budgeting does not receive a true test.

Payers are not willing to give hospitals a lump sum and the discretion to use it. Payers want an accounting and the return of unspent money. Therefore they insist on detailed expenditure reports, in order to recapture past overpayments and grant a tighter budget next time. Hospitals take advantage of such end-of-the-year settlements to ask for shortfalls. The possibility of doing so leads them to take a chance and overspend during the year. If end-of-the-year settlements

are common, global budgeting works much like other cost-based payment systems.

Hospital managers do not get all the discretion they foresee. Accountability and detailed reporting will still be required.

Because hospital wages follow those in the rest of the economy and because medical care keeps adding new technology and new subspecialties, hospital costs inevitably rise. Like other cost containment measures, global budgeting works at the margins.

All providers can be required to share a global sum, even if they remain private. Doctors may compete with each other vigorously. Proprietary hospitals may do so too, since they are extensions of doctors' individualistic office practices. But nonprofit hospitals may not behave as natural economic competitors at all. Faced by a common ceiling, they may collaborate in a division of labor, enabling each to become outstanding in a different specialty. The economic behavior of people (like doctors) differs from the economic behavior of organizations, particularly charitable ones.

Some administrative savings can result from global budgeting:

1. The flow of money out of the third parties and into the hospitals is predictable and even. Hospitals can commit themselves to personnel. They need not take out short-term loans.
2. Individual billing disappears, along with statistics based on it.
3. End-of-the-year expenditure reports still survive, if the payers insist on scrutiny. But they are more aggregated than might be required by other payment systems.

A central agency is needed in some form:

1. Only one payer might exist, usually government.
2. One fund exists, pooling the contributions from several payers. All must follow the same payment rules, particularly on allowable costs.
3. One agency to work out the payment rules, if multiple payers exist. Then they can send their lump sum installments individually.

## FOOTNOTES

1. As in Aaron Wildavsky, How to Limit Government Spending (Berkeley: University of California Press, 1980).
2. Hospital Statistics (Chicago: American Hospital Association, 1980), pp. xvii-xxi.
3. Papers by Mary Grogan Brown, Bernard Weinstein, and Yoshi Honkawa, in Commission on Public-General Hospitals, Readings on Public-General Hospitals (Chicago: Hospital Research and Education Trust, 1978), pp. 46-51 and 423-450.
4. Harvey M. Sapolksky, "America's Socialized Medicine: The Allocation of Resources within the Veterans' Health Care System," Public Policy, Volume 25, Number 3 (Summer 1977), pp. 359-382.
5. Weinstein, op. cit. (footnote 2, supra).
6. Harold A. Cohen, "Are Price Controls Effective?," in Blue Cross and Blue Shield Associations, Health Care in the American Economy: Number 3 (Chicago: Health Services Foundation, 1980), pp. 92-93; and Abt Associates, Case Study of Prospective Reimbursement in Maryland (Washington: Health Care Financing Grants and Contracts Report, 1980), pp. 15-19, 44-46, and 95.
7. The formulae are summarized in Abt Associates Inc., Case Study of Prospective Reimbursement in Massachusetts (Washington: Health Care Financing Grants and Contracts Report, 1980), pp. 40-44.
8. Impact (Burlington, Mass.: Massachusetts Hospital Association, 2 volumes, 1978 and 1980). The Association and individual hospitals filed many lawsuits challenging the successively stricter Medicaid limits as violations of the statutory commitment to reimburse the hospital's costs.
9. Some of this is described in Bruce C. Vladeck, Unloving Care (New York: Basic Books, 1980), pp. 86-89.
10. Glaser, Paying the Hospital in England and Paying the Hospital in Canada.
11. The wrangling in Canada under bottoms-up budgeting is described by Lloyd F. Detwiller, in International Federation of Voluntary

Health Service Funds, Third International Conference Proceedings, 1970,  
pp. 18-19.

12. Robert J. Maxwell, Health and Wealth (Lexington, Mass.: Lexington Books, 1981), p. 45; and "Cost of the NHS" (London: Office of Health Economics, 1978).

13. Also in Glaser, Paying the Hospital in Switzerland, Ch. VII, pp. 17-21, and Ch. IX, pp. 6-7.

14. Glaser, Paying the Hospital in France, Ch. XII, pp. 8-11.

15. The system is described in Theo Siebeck, "Das Vergütungssystem in Kassenärztrecht," Die Ortskrankenkasse, Volume 45 (1963), pp. 501-516.

16. The history and repeal of global budgeting for ambulatory care in Frieder Naschold, Kassenärzte und Krankenversicherungsreform (Freiburg im Breisgau: Verlag Rombach, 1967); and Deborah A. Stone, The Limits of Professional Power (Chicago: University of Chicago Press, 1980).

17. The conference machinery recently installed in Germany (the Konzertierte Aktion) is described in Henry A. Landsberger, The Control of Cost in the Federal Republic of Germany (Washington: Bureau of Health Planning, Public Health Service, U.S. Department of Health and Human Services, 1981).

18. Naomi Caiden, "Problems in Implementing Government Expenditure Limitations," in Wildavsky, How to Limit Government Spending (op. cit., footnote 1, supra), pp. 143-162.



## CHAPTER IX

### COVERING THE HOSPITAL'S COSTS

#### COST REIMBURSEMENT V. CHARGES

Issue. Some Americans have debated the basic method: should the hospital's "costs" be fully reimbursed, should its revenues come from "charges," should another principle be used, or should a combination generate revenue? To Americans, "cost reimbursement" conjures up a blank check for the hospital: it does what it likes and then sends the bills. "Charges" are thought to be set in advance with tenuous or no relations to the likely costs. The usage is due to America's peculiar financial history.

As I said earlier, for many years hospitals in all countries raised their own money from a variety of sources. Some patients were asked to pay "charges" for basic care and, particularly, for extra services. The "charges" were fixed arbitrarily, often on a sliding scale of patients' abilities to pay. Exact cost accounting hardly existed in business and government, let alone in hospitals. There was no thought of covering all the hospital's expenses through patient fees, so the impetus for cost accounting was absent.

European sick funds and other third parties began to pay for patients' care. They represented the patients and not the hospitals and therefore scrutinized the hospitals' charges skeptically. Some governments appointed regulators to approve hospital charges, and the regulators expected the hospitals to justify them. The regulators tried to protect the third parties' money by making the hospital more efficient.

The Anglo-Saxon countries developed third party payment later than Europe. No consumer-oriented sick funds drove hard bargains. Until recently, no public regulators acted as impartial arbiters to fix fair charges. Britain developed hospital contributory schemes to enable the hospital to cover some operating costs until subscribers needed care; and

North America developed Blue Cross to prepay the subscribers' hospital expenses, when needed.

As I reported in Chapter III, supra, many state Blue Cross Plans attempted to pay charges that would equal the probable costs of those patients' care; others committed themselves to charges that did not necessarily bear a relationship to cost. The former implied direct payment to the hospital; the latter implied a cash indemnity to the patient, who paid whatever the hospital charged. The former was feasible in states where Blue Cross had many members and high premiums; the latter in states with few members and low premiums. Hospitals still had to collect much revenue from other sources, such as other patients, gifts, and endowment income. Unable to survive adequately, the hospitals in Britain and Canada supported the movement to governmentalize payment and to use global budgeting.

American hospitals remained under private managers or under independent municipal authorities. Until recently, they did not have to face tough negotiators and skeptical regulators. The mission of Blue Cross Plans was to help the hospitals, and they let the hospital managers define the costs that Blue Cross was expected to reimburse, viz., their calculations of the costs of treating each Blue Cross patient. All hospitals have had charge schedules for billing patients who pay directly, and Blue Cross paid these charges -- less whatever discounts it could negotiate -- in states where the Plan lacked the financial capacity to commit itself to paid-in-full cost reimbursement, or where the hospitals were unwilling or unable to pay the cost of the Blue Cross patients.

Cost reimbursement in the United States was thought "permissive" and "retrospective." Charge payments were thought "fixed" and "prospective." Cost reimbursement required agreement on interim rates between hospitals and the state or regional Blue Cross Plan at the start of the year, usually last year's, updated as the hospital manager wished. At the end of the year, the manager submitted a detailed estimate of the costs of the Blue Cross patients. Blue Cross then paid the difference between its earlier payments when billed at the interim rate and the final estimate. As payments pressed on its reserves, the Plan asked the state insurance commissioner to approve higher premiums.

Charges were final. No end-of-the-year settlements would review those patients and add additional payments from Blue Cross. However, the hospital might increase its charges at any time and might alter the structure of the schedule. Hospitals might earn profits or incur losses from their charges, but not from cost-based reimbursement. Only the hospital managers knew the true profits and losses -- and not even then, if their internal accounting was crude.

During the 1950's and 1960's, the American Hospital Association and the National Association of Blue Cross Plans adopted several policy statements endorsing cost-based reimbursement as the proper way to pay hospitals. When the Medicare-Medicaid bill was being written during 1965, the outcome was uncertain. NHI bills had repeatedly been defeated in American history, with great political damage to their sponsors. In order to get the cooperation of the AHA and Blue Cross, the drafters pledged that hospitals would be paid the "reasonable costs" of patients' care. The AHA would have preferred a pledge of complete "current costs," the language in its policy statements alone and with Blue Cross. But Congress feared an unlimited commitment: public money would pay "reasonable costs" but not unreasonable costs, and the criteria would be specified in regulations.<sup>1</sup> This laid the basis for public scrutiny over the finances of hospitals, a task not done by the Blue Cross Plans.

Difficulties. Medicare, Medicaid, and Blue Cross, during the 1960's and early 1970's, were criticized for uncritically paying whatever the hospitals wanted. This was said to encourage acquisition of more equipment, hiring of more people, generous wages, and waste. Cost reimbursement was said to be the principal reason for the great increase in health spending during the late 1960's and 1970's, an important cause of inflation in the larger American economy. The infusion of money into health care led to a large infusion of economists into health services research, to explain the trends and suggest alternatives to cost-based reimbursement.

One set of reforms was periodic tinkering with the Medicare-Medicaid law, so that "reasonable costs" were isolated only for program

beneficiaries and would contain no waste.\* Every hospital was required to submit detailed expenditure reports to the fiscal intermediary and to SSA (later HCFA). The government as purchaser was armed with a battery of formulae for disallowing or reducing certain items in the hospitals' cost reports. Each revision complicated the payment system, outraged the hospitals, led to compensating increases for charge-payers, and left unsatisfied the advocates of entirely different payment methods.<sup>2</sup>

Another set of reforms was directed at Blue Cross. When hospitals expanded their payrolls and facilities for their now affluent Medicare-Medicaid business, they charged those costs as well to the Blue Cross patients who used them. So, the periodic Blue Cross applications to insurance commissioners asked for steadily larger premium increases, reaching 25 per cent or more annually during the early 1970's. Several insurance commissioners (such as Pennsylvania and Rhode Island) conditioned Blue Cross rate increases on creation of prospective examination of hospitals' budgets and on setting prospective rates on the basis of strict negotiation. The previous pattern of permissive interim rates and generous end-of-the-year settlements was abandoned by those Plans committed to cost reimbursement. Costs were to be predicted and hospitals were expected to stay close.<sup>3</sup>

Between 1965 and 1981, Medicaid adopted the same cost reimbursement rules as Medicare for inpatient hospitalization. The burdens on the social security and Blue Cross funds were therefore paralleled by the drain on state and national welfare budgets. With the encouragement of the national government, several states adopted prospective rate regulation of hospitals. The immediate need was to control Medicaid costs, but this could be done only by scrutinizing each hospital's entire budget, both in advance and during the end-of-the-year settlements. Unlike the earlier cost-reimbursement methods of Blue Cross and Medicare, the hospital was expected to keep within the prospective budget and had to justify supplementary demands in the end-of-the-year settlements. I described several state regulatory programs in Chapter VI, supra.<sup>4</sup>

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\*The basic definition is: "The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services...." The Social Security Act, Sec. 1861 (v)(1)(A).

A problem in administering cost reimbursement was that each payer was pledged to pay the costs only of its own subscribers, not a fraction of the average costs for the entire hospital. Medicare-Medicaid and Blue Cross had slightly different definitions of the costs they would cover. The government could be adamant -- the fiscal intermediary and SSA could claim that their hands were tied by regulations -- but the Blue Cross Plan might be flexible in negotiations. As a result very elaborate calculations were necessary, particularly in the states where all three third parties used cost reimbursement. The detailed end-of-the-year report submitted to satisfy Medicare was computerized and subjected to two analysis programs. One isolated the costs for the hospital's Medicare, Medicaid, and Blue Cross business during the year. The second struck from the totals for each the amounts each did not cover under its rules. The method was complicated. It left a substantial balance, viz., the full costs for everyone not covered by a cost-based program (such as the commercially insured and the self-payers) and those costs Medicare, Medicaid, and Blue Cross refused to cover at all in their own accounts.

In its role as principal payer for its own subscribers and as fiscal intermediary for Medicare, the Blue Cross Plan is not unhappy if many costs are loaded upon the payers of charges. The commercial insurance companies have no place to take their complaints in most states.<sup>5</sup> When a state has a regulatory program, these officials eventually seek equity among all their payers, not lids on Medicaid expenditure alone. They cannot condone price discrimination and the shifting of obligations; a single set of rules about costs and rates is easier to administer than a mixture. All regulatory agencies have pressed Blue Cross to accept nearly the same rules as self-payers and to reduce discounts. Several agencies have gotten HCFA waivers, so that Medicare and Medicaid have nearly the same contractual allowances as the Blues and others.

In theory, a system of charges might seem more attractive to a provider than cost reimbursement. The doctor or hospital is free to create his (its) own facilities through self-financing and set his (its) own prices; he (it) need not report or explain to anyone; and he (it) might earn large profits. The method works very well for physicians, and most in developed countries have always been paid by fee-for-service,

albeit now by negotiated fee schedules. The method is advantageous for hospitals only if they can dictate their own charges, collect from all their patients, and gain high returns from even the most expensive patients. American nonprofit hospitals have had many patients with high costs and little financial capacity, so by the 1940's they preferred the protection of cost reimbursement. The proprietaries and some nonprofits could survive on a charge system, by avoiding very expensive and indigent patients, and by taking advantage of indemnity insurance policies that permitted extra charges to patients over the insurance benefits.

But a charge system incurs suspicions of profiteering and underservicing, and third parties fear that all their subscribers are carrying an undeserved burden. Hospitals have not had to cope with state regulators in states where charge methods are common, but they did have to face Blue Cross. The Plans wanted to negotiate the charge schedules and sought financial justifications for the hospitals' prices. Although reporting and investigation are less than in states where Blue Cross pays by cost reimbursement, unilateral pricing by the hospital management is replaced by prospective "controlled charges" or "negotiated rates."<sup>6</sup> The hospital can be totally independent only by refusing to sign a Blue Cross contract, and that may be too risky.

Because it is a typical form of business pricing, charge systems attract critics of cost reimbursement and advocates of business-type competition among hospitals. For example, one of the principal "pro-competition" bills before the present Congress would abolish all hospital rate regulation and all cost-based reimbursement.<sup>7</sup> Like any unregulated business, a hospital would set whatever charges it could collect, whatever charges would enable it to survive economically. It would develop those services, pay those wages and prices that would enable it to survive under the charges it could collect. The relation between its charges and those of competing hospitals would determine its share of the market. The for-profit sector in health would probably grow, if this plan were enacted, since prices would not be restricted to costs and since ambitious entrepreneurs would be attracted into the industry.

An oddity of certain American payment systems is allowing one side (either the payee or the hospital) to select either one method or

its very opposite. That side picks the more advantageous one, and then the other side struggles to cut down the advantage. For example, at one time the hospital could select among different methods for dividing the costs of its Medicare patients from the total costs of all its operations (i.e., the "departmental" or "combination methods").

Instead of adopting either cost reimbursement or charge payment as its universal principle, the Medicare fiscal intermediary must choose whichever is lower. First, the share of a total hospital's operating costs are identified for the Medicare patients. Then, these costs are reduced for the average Medicare patient according to the Medicare principles of "reasonable costs." The costs for that average patient are then compared with the total set of charges that patient would incur if Medicare would pay his charges and not his costs. Medicare then pays for that hospital's Medicare patients the "reasonable cost" estimate or the "charge" estimate, whichever is lower. This method creates great calculating efforts for all sides and disputes over arithmetic. The hospital finance officer is motivated to rearrange his cost assignments to make sure that costs and charges are similar for the main divisions in hospital reimbursement -- i.e., particularly in the separate inpatient and outpatient accounts. For example, if costs exceed charges in the inpatient side and if charges exceed costs in the outpatient side, the finance officer in his books reassigned some of his personnel from the inpatient to outpatient accounts, such as administrators' salaries. The change is completely on paper; the work of the personnel and the operating costs of the hospital do not change. But the juggling prevents a shortfall in the revenue. Such manipulation is common in the cat-and-mouse relations between payers and hospitals in the United States.

Evolution abroad. Doctors in Europe and North America for many years were paid by charges that they alone set. As I said in Chapter III, supra, health insurance in Europe began as a method of paying the doctor and as a method of protecting the subscriber's income when he could not work. At first, the sick funds reimbursed patients according to the funds' financial capacities, and these reimbursements had no necessary relationship to the doctors' charges or the doctors' costs. Some doctors agreed to accept certain sick funds' payment schedules as direct payment in full.

Third party payment in full could not be based on whatever the doctor wanted, and rates were set by negotiation or by contract. Certain flat rate methods were designed to cover the doctors' costs and give him a predictable personal income. Where fee-for-service was retained, each side started bargaining from rival charge positions; the medical association proposed fee schedules with much higher charges, the sick funds offered schedules at much lower charges. The only objective basis on which they could converge has been cost-plus: in every country, the two sides estimate the costs of performing each act on the fee schedule in the doctor's office, estimate the number of acts of all sorts he is likely to perform in a normal work year, and add to the cost of each act an honorarium that will result in a reasonable income during the year. The two sides dispute the costs of each act and the proper net income for a doctor, but an attempt to base fees on the medical profession's costs is fundamental and universal. In payment systems involving third parties, the definition of costs is not left to doctors alone (either individually or collectively) and the payers do not automatically accept each doctor's estimate of his own costs.

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Only in completely private practice abroad does a pure charge system exist. The doctor sets whatever figure he thinks is fair or whatever he can collect from that patient, without any relation to his costs or to a fee schedule. But few completely discretionary transactions are left in developed countries.<sup>9</sup> Lest the professional and patient grape-vines judge them rapacious, doctors in their private fees usually stay close to the official NHI fee schedule or to the indemnity schedule by which private insurance companies reimburse patients.

When foreign hospitals began to charge patients and when sick funds began to cover hospitalization, the prices were not yet calculated according to careful cost-finding. Hospital costs were rising, and hospitals needed to find new revenue, but most (or much) of their revenue came from additional sources. Sick funds reimbursed patients according to a schedule of what they could afford. Hospitals varied, with some offering more comfortable facilities and better doctors at higher prices to those who could afford them. Some comparison-shopping by patients might have occurred.

National health insurance was enacted to enable more persons to get better care and also to put hospitals on a stronger financial base. All the statutes presumed that the costs of each patient's care could be calculated, and sick funds would pay each hospital neither more nor less than those full costs.

Payment of the doctor would use cost-plus; payment of the hospital would use costing alone. Since the thousands of doctors could not be investigated individually and since so many were hostile to the sick funds and refused to submit their books, their average costs would be estimated; but each hospital's costs would be accurately identified individually. Since the doctors' fees included personal income as well as reimbursement of their operating costs, the fees would be bargained adversarially; but since the hospitals would earn no profits, their accounts and prospective budgets would be examined in a fact-finding style.

Current methods abroad. The NHI statutes permitted the hospitals and rate regulators to simplify administration by averaging all the patient costs in a standard daily charge (i.e., the prix de journée, pflegesatz, verpleegprijs per dag, etc.). Once merely a price arbitrarily set by the hospital, the daily charge became the administrative vehicle for cost-based reimbursement: all patient days multiplied by the daily charge equalled no more and no less than the full costs of all patient care. Every organized payment system (except for global budgeting) employs such averaging methods, so that the outcome as a whole -- not the bill for each individual patient -- is accurately cost-based. But, of course, the difficulties are in implementation, viz., the empirical problem of estimating the financial costs of services; the normative problem of deciding what the hospital should be allowed to do.

Switzerland retains a vestige of the charges of past years, viz., the daily rate of the sick funds.<sup>10</sup> Once these were charges set by the hospital and paid by the patient. The owners of the hospital paid the rest. The sick funds eventually took over in full the charges for clinical care (the Spitaltaxen); other charges for living costs (Pensionszuchläge) were paid by the patient out-of-pocket or by special supplementary insurance policies. Swiss sick funds never could afford

to take over payment of all costs in full, because the absence of a payroll tax on employers limited their finances. The cantonal governments had always paid from general revenue the difference between patients' charges and the full costs of the publicly owned hospitals, and eventually they paid most of this difference for all. A system of charges survives for the sick funds' share, but the full amount (charges plus subsidy) is full reimbursement of costs.

The charge for clinical care (the Spitaltax) remains an arbitrary figure. In many cantons, the committee of sick funds and the hospital association meet and negotiate the rate for the next year, the hospitals then submit their detailed budgets to the cantonal government, and the government is asked to pay the deficit. Since the size of the Spitaltax determines the size of the canton's subsidy, the officials of the cantonal ministry of health usually try to influence the negotiations. In a few cantons, such as Zurich, the cantonal government plans both its subsidy and the Spitaltax in advance, and the sick funds go along. The relative sizes are a matter of social policy, viz., whether to support the hospital primarily out of general revenue or out of premiums from the employed subscribers. The charges no longer arise out of marketplace bargaining as they did years ago. The hospitals have never had to operate within them, and even less so now. Hospitals neither in Switzerland nor in other countries can live on charges alone for very long; particularly if they are nonprofit, they seek additional funding to ensure stability, and nowadays that eventually results in coming to government.

A few hospital prices are charged for extra services not included in the comprehensive daily rate or in the global budget. In a few countries, the hospital management -- both in the nonprofits and proprietaries -- are allowed to set the prices according to their estimate of the market. An example is the rates for single-bedded and two-bedded rooms in West Germany. These are considered private transactions between patient and hospital, not paid for under statutory health insurance and therefore not the responsibility of the sick funds. The hospital management is motivated to charge high prices and collect them, since it is allowed to keep about half the revenue for discretionary expenses. The

rest is supposed to be reported within the budget (on the Selbstkostenblätter) and therefore is a deduction from the total the sick funds would have had to cover.

When a country has a regulatory agency, usually all hospital prices fall under its jurisdiction. Hospitals should not profiteer even in the uninsured transactions. An example is France, where the higher rate for the private room is not supposed to exceed the extra operating costs. Another example is Holland, where COZ has the task of screening the private hospital prices under a price surveillance law, and COZ advises the government whether the single-bedded and two-bedded room prices of hospitals are justified by their costs.

In most countries, proprietary hospitals are still treated as if they are extensions of the doctors' practices rather than typical hospitals, paid by the statutory cost-based methods. While free to charge a great deal and become profitable, only a few unusual elite establishments succeed.

Most proprietaries attracting patients for cash in a free market must charge considerably less than the nonprofits participating under national health insurance. The patient is willing to pay a private fee to the doctor, provided he does not have to pay too much for the hospital costs too. If the patient relied on his national health insurance coverage for the same care, he might not have any out-of-pockets for either the doctor or the hospital.

Proprietary hospitals abroad cannot survive without some business from the official sick funds. The sick funds have the advantage when negotiating charges with the proprietaries, since they are not obligated by law to pay their costs.\* As a result, the proprietaries accept charges lower than those of the public and confessional hospitals protected by the cost-based reimbursement clauses of the national health insurance laws.

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\*The only exception is West Germany, where some proprietaries are full participants in the provincial hospital plans. They reveal their full costs in the Selbstkostenblätter, and they negotiate with the sick funds a daily charge covering costs in full, exactly like the nonprofits. A profit is not an allowable cost.

## PROSPECTIVITY

United States. Americans equate charges with prospectivity and cost reimbursement with retrospectivity. A charge is supposedly like any businessman's price, it is known before the customer purchases the service, the company must work within the revenue, the seller cannot ask for more upon delivery if he seems to be losing money, and the buyer cannot ask for a refund if he suspects the price was too profitable. The deal was firm.

Americans perceive cost reimbursement as a commitment by the purchaser to whatever costs the producer incurred. The producer calculates the costs after the work is done. Installments may be paid in advance, but these are not tentative rates.

No other country defines cost reimbursement in this fashion. The Americans do only because of peculiar circumstances. Blue Cross and Blue Shield originated to help the hospitals and doctors find money; they were designed to avoid any restrictions on the complete freedom of hospitals and doctors to organize their own practices and set their own charges; because Blue Cross often and Blue Shield always paid only fixed indemnities to patients, the patients were left with the direct financial relationship with the providers, and the Blues were not obligated to pay full costs. Only when some Blue Cross Plans began to contract with hospitals to cover the costs of their patients in full did they have to think about hospitals' financial practices; but the Plans were not supposed to infringe on the hospital managers' prerogatives by questioning their estimates of costs. Peace reigned as long as Blue Cross could get constantly higher premiums; but state insurance commissioners objected during the early 1970's, and the Blue Cross Plans pledged to full cost reimbursement had to limit their commitments.

Blue Shield had similar dilemmas. Doctors were accustomed to charging patients as they liked and thought of Blue Shield as a method of helping the patient. Hardly any American office doctors had regular financial relations with a carrier. Blue Shield was widely criticized for inadequate coverage of doctors' fees and had to improve, in the light of their subscribers' complaints and in the light of competition

by insurance companies. To cover more of the doctors' charges, Blue Shield raised premiums, but eventually the state insurance commissioners objected. Unlike hospitals, doctors would not agree to organized negotiations and scrutiny of their costs; no law (like Medicare Part A) required doctors to file cost reports for any other purposes. To satisfy both its needs and Medicare Part B, Blue Shield developed the ingenious method of "Usual, Customary and Reasonable Charges" (UCR) to restrain the exceptional above-average charges. It is restraint without prospective controls or retrospective audit of costs, and it is voluntary. (The version for Medicare is called "Customary, Prevailing, and Reasonable Charges" or CPR.)

The Medicare and Medicaid law of 1965 committed the payment system to cost reimbursement. It conferred upon the national government and its fiscal intermediaries no authority to fix rates in advance for either hospital or ambulatory care. Well aware of the universality of prospective reimbursement and fee schedules in other countries, the national and most state medical associations had long opposed national health insurance in the United States as opening wedges for such controls, and they opposed passage of Medicare as well. American politicians seek credit for passing legislation, regardless of outcomes; if they cannot enact something because restrictive clauses bother a key interest group, they would rather compromise in order to "get a bill." In order to enact the first American national health insurance law, the decision-makers (Wilbur Mills, Lyndon Johnson, Wilbur Cohen) omitted any explicit references to prospective controls or close scrutiny of costs, that would arouse the fatal opposition of hospitals and doctors. The law created direct third-party payment obligations without restraints. No other country would legislate in this way.\*

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\*Confronted by a medical profession as fiercely independent as America's, France in 1928 adopted national health insurance committed only to pay indemnities to patients for doctors' care. The law did not purport to pay for ambulatory care in full. Not until thirty years later was the law revised to control the doctors' charges. Prospective third party reimbursement of the hospital was already in place in 1928: the prefects had been setting the prix de journée for all payers for some time.

Blue Cross and the Medicare system have been struggling to change from retrospectivity to prospectivity, while also preserving the commitment to reimburse costs. Blue Cross has a freer hand, since it is private; a Plan can become quite independent of the hospitals (particularly under pressures from the state insurance agency) and can try to get prospective budget review written into the contract with the hospitals. In some states, hospitals have gone along with prospective rate-setting on several conditions: it is presented as a "demonstration experiment"; it includes generous end-of-the-year settlement; the hospital is allowed to increase rates during the year to avoid cash-flow problems; and the system is revised quickly in response to complaints. In other states, the hospitals have agreed to virtually permanent prospective reimbursement arrangements with Blue Cross, in order to avoid worse evils, such as denials of all premium increases by the insurance agency and creation of a state hospital regulatory agency. Once a fund-raising agency for the hospitals, Blue Cross has become an intermediary between the hospitals and state governments.

The result now is a negotiating system, instead of the earlier method of automatic payment. The state or regional Blue Cross Plan negotiates a model contract with the state or regional hospital association, defining relations between the Plan and the individual hospital throughout the year. The contract also sets rules for the detailed negotiation between Plan and hospital over its daily rate. Before the start of the fiscal year, the hospital submits to the Plan office a prospective budget and an application for new and higher rates. The Plan's statisticians examine it in the light of the hospital's last final expenditure report and (in some Plans) with budgets of peer group members. After some discussions and possible cuts, the hospital starts the new fiscal year with a tentative interim rate. During the year in many states, the hospital files brief quarterly statements and the interim rate is increased. At the end of the fiscal year, the hospital files audited expenditure statements with both the Blue Cross Plan and the Medicare fiscal intermediary -- often the same agency -- and the Blue Cross staff investigates, often using peer group comparisons as well as internal statistical analysis. After discussions between the Plan and

the hospitals, a final rate is agreed on for the previous year. The Plan pays shortfalls or the hospital sends back overpayments.

Blue Cross in many states therefore has evolved from a retrospective to a prospective method, both ultimately reimbursing costs. During the year, Blue Cross's surveillance now can restrain the increase. But presumptions do not yet exist that the hospital's final expenditure report should be close to the initial prospective budget, that the first interim rate should have been enough throughout the year. The many interim increases during the year weaken the prospectivity and cost containment. (Even some supposedly ferocious state regulatory programs have proved to be paper tigers because of frequent interim rate increases. They produce a higher final result.)<sup>11</sup>

Medicare's retrospective cost reimbursement is entrenched in law. Any attempt to shift to prospective rate setting and to force hospitals to live within prospective budgets can be nullified in courts. Blue Cross can move toward prospective methods and (if it is determined) toward a tight lid without end-of-the-year settlements. But such a change for Medicare requires an Act of Congress. Interim rate increases are issued when prospective budgets are filed at the start of the year; in contrast to the optional methods that vary among state Blue Cross Plans, the hospital everywhere automatically gets higher rates when it files interim expenditure reports. The Medicare program tries to contain costs by interpreting the coverage in the statute narrowly and by applying certain ceilings to the more expensive hospitals. These exclusions must be applied to the hospital's final expenditure reports.

Current methods abroad. Providers everywhere desire the best of all arrangements: setting their own prices and collecting all they want. Payers desire another ideal combination, viz., maximum service at minimum expense. A compromise in every country is prospective rate-fixing. Only in Belgium do the doctors still have enough political power to resist price controls from government and the sick funds, but the Belgian sick funds achieve predictability by negotiating a patient indemnity schedule with the medical association. Retrospective payment commitments are avoided because governments and sick funds in every country have long taken for granted what the Americans belatedly discovered under Medicare,

viz., when guaranteed "full" or "reasonable" costs and charges, providers charge a great deal and build up their facilities.<sup>12</sup>

Every developed country has long reached the point where Blue Cross seems to be going: the third party is committed to paying the costs of giving adequate services; a rate or total budget is set by negotiation at the start of the year; deficits and shortfalls are corrected upon examination of an audited expenditure report at the end of the year. The method guides government rate regulators in France, the joint commission in The Netherlands, the bilateral negotiators in West Germany, and the government grantors in Canada and Switzerland. The end-of-the-year settlements are earmarks of a cost reimbursement system. In a charging system -- as in the payment of proprietaries in France and many hospitals in the western half of the United States -- the initial charge is final.

Prospectivity has steadily increased in all methods of paying hospitals abroad. The initial rates (whether set by regulation or by negotiations) are expected to last for the year; the global budgets (whether paid by one government agency or covered by mixed sources) are the limits for all work. End-of-the-year settlements always are performed, but changes in the payment more and more are restricted to compensating for things the hospital could not control, such as deficits due to higher utilization than predicted. Countries that still have end-of-the-year settlements to cover cost increases, such as Holland, have higher hospital expenditure increases (i.e., as both cause and effect) than countries virtually without them, such as Germany.

Interim increases disappeared abroad during the late 1970's, except to remedy crises due to unexpected increases in utilization. For example, once every French hospital submitted a supplementary budget during the year and most got interim increases, but the national government eliminated them during the late 1970's. The hospital had to work within the initial budget and try to get a retroactive increase at the end of the year. Likewise, the supplementary appropriations under global budgeting in Britain and Canada became much scarcer during the late 1970's.

If hospitals are supposed to maintain the same unit costs under strict prospective reimbursement, they might still spend more and attribute it to higher utilization. All the rate and global budgeting arrangements in Europe and Canada include advance review and agreement about expected services in great detail. It is assumed that the aggregate expected costs and the line-by-line costs are sufficient to cover expected services for the several departments. If the hospital wants a retroactive increase at the end of the year for higher costs without commensurate increases in utilization, only an unusually strong case (such as unexpected national wage agreement) will get the extra money. The regulators and granting agencies examine evidence of higher utilization carefully, to be sure it was justified by increased population or by higher morbidity, and not manufactured by the doctors and hospital managers. In order to plan global budgeting carefully in some Canadian provinces (such as British Columbia), the Ministry of Health decides not only the total amount of money but the hospital's target utilization level, such as number of patient-days. The utilization projections are based on demographic research. Maximum levels of personnel and expenditure are predetermined by this level of utilization, according to the ministry's statistical guidelines. The hospital's global budget must be no higher.<sup>13</sup> During the year, the hospital does not turn patients away but must explain deviations from the expected service levels. Extra payments to one hospital should be offset by savings from another, if patients went to the former instead of to the latter.

Mere manipulation of numbers is not enough. Regulatory and granting agencies in Europe and Canada assign auditors or other liaison officials to particular hospitals. They learn the affairs of the hospital through professional conversations with the management and through site visits. Occasional or regular site visits by auditors occur during the discussions of the prospective budget and final expenditure report. The liaison officers -- such as those in the Ministry of Social Affairs of Quebec -- visit and telephone often. The hospital becomes more than a financial report, and the auditor can participate in changes in structure and services, if financial cuts are necessary. He can evaluate the hospitals' claims for more money and against cuts, instead of being arbitrary. The hospitals may then appeal less often and less stridently.

## ALLOWABLE COSTS

Issue. If a payer reimburses the hospital's "costs," the problem is the meaning of costs. In every country, the organized payment system covers some items but not others. The complication in the United States is the slightly different lists of allowable costs among the principal payers. It is not merely that each payer wishes to pay only for its own subscriber; each payer defines the cost base for its subscribers a bit differently. If all payers agreed, paying the American hospital could be simple.

Exclusions from allowable costs by the principal payers are:<sup>14</sup>

| <u>Item</u>  | <u>Payer</u>   |
|--|--|
| Amortization of principal and interest in debts incurred for new buildings and equipment | Medicare, Medicaid in most states, Blue Cross in some states                       |
| Charitable care for the poor   | Medicare, Medicaid, Blue Cross in some states                                      |
| Bad debts from patients not covered by that payer  | Medicare, Medicaid, Blue Cross in some states                                      |
| Malpractice insurance premiums for the hospital as a whole                               | Medicare   |
| Research   | Medicare, Medicaid, and Blue Cross in many states                                  |
| Credit and collection costs  | Medicare, Medicaid, and Blue Cross in some states                                  |
| Special items: blood, prostheses, etc.   | Blue Cross in some states, depending on subscriber policies and provider contracts |

Blue Cross Plans vary in allowable costs. Therefore, in some states the formulae for depreciation and interest are the same as for Medicare-Medicaid. In other states, the calculating rules differ. The limits of reimbursable educational costs are drawn similarly by Blue Cross and Medicare-Medicaid in some states, differently in others.

The hospitals have been able to persuade or compel payers to pay some items that are unheard-of or unusual in Europe and Canada:

Completely explained lines, such as a "plus factor" or a "return on equity."

Legal costs from suing the third parties in payment disputes.

Many amenities for the staff, including perquisites for the managers.

Entertainment.

Fund-raising costs.

Depreciation on assets purchased with public funds.

Costs of fighting unions.

Losses on business activities, such as parking lots, gift shops, and staff cafeterias.

Costs of corporate headquarters, including shares of the office of a multihospital chain; and shares of the motherhouse of a religious order.

Difficulties. A great administrative effort is placed on the hospital, to distinguish each patient by his payer and not merely by his clinical condition, and then to follow different cost-finding and cost-assignment calculations for each payer. Instead of thinking they have one budget with all payers contributing jointly, hospital finance officers think they have a distinct budget for each payer.<sup>15</sup> They must understand their own separate accounts but must not make them too lucid for the benefit of regulators and the auditors of payers, since they want freedom to juggle.

If the finance officer faced payers (whether a few or several) with the same allowable costs and the same payment rules, he could not earn more per patient-day from one than from another. But under American conditions, he can, and American hospital finance officers have become experts in maneuver. Like the tax laws, a complicated payment system has had corrupting effects. The juggling occurs because each third party is concerned only with its own payments, does not know about payments by others, and is pleased when it can save money at the expense of others. What stricter cost reimbursers (Medicare and Medicaid) refuse to pay for is reassigned, if possible, to the accounts charged to a permissive cost

reimburser (Blue Cross). Since these carriers pay for costs incurred in treating their subscriber, the art is to assign in the books to each set of subscribers the activities of the hospital that will produce the highest possible payments from all of them. This must be done without flagrantly violating rules of cost assignment, since the carriers then could object.<sup>16</sup>

What the cost reimbursers flatly refuse to pay for can simply be loaded onto the bills of those who do not get cost assignment explanations as a condition of payment and who are merely obligated to pay whatever the hospital asks, *viz.*, the self-paying patients and those patients who are reimbursed in whole or in part by commercial insurance companies. The insurance companies then have a great disadvantage in competing with Blue Cross. For this reason, the companies have a low market share in states where Blue Cross reimburses costs, a higher market share where Blue Cross (like their subscribers) pays posted charges. In states where the cost reimbursers cover most patients and the hospitals overload the charge-payers, the charge-payers become steadily fewer and the differential loaded on to them steadily larger. HIAA estimates that the shift of costs from Medicare-Medicaid to the entire private sector (Blue Cross and all charge-payers) has steadily risen:<sup>17</sup>

|   | 1975  | 1976  | 1977  | 1978  | 1979  | (1980)<br><u>projected</u> | 1981<br><u>projected</u> |
|---|-------|-------|-------|-------|-------|----------------------------|--------------------------|
| Short-term hospitals throughout U.S.        |       |       |       |       |       |                            |                          |
| 1. Average payment per adjusted patient-day | \$125 | \$141 | \$160 | \$178 | \$198 |                            |                          |
| (a) Medicare-Medicaid                       | \$137 | \$160 | \$185 | \$211 | \$239 |                            |                          |
| (b) Private sector                          |       |       |       |       |       |                            |                          |
| (c) Differential                            | \$ 12 | \$ 19 | \$ 25 | \$ 33 | \$ 41 |                            |                          |
| 2. Total cost-shift in billions             | \$1.1 | \$1.3 | \$1.8 | \$2.4 | \$3.0 | \$3.9                      | \$4.8                    |

Within the private sector, says HIAA, the shift is borne principally by the charge-payers. Blue Cross Plans reimbursing costs and enjoying discounts are insulated from Medicare-Medicaid shifts and shift some of their own true costs to the charge-payers.

The foregoing is a mere shift and is simple. The true challenge to the juggler of books is to assign costs to the strict cost reimbursers, taking advantage of their rules, while avoiding disallowances because of flagrant maneuvers and excessive increases. An opportunity is presented by the retention of the hospitals' traditional right to set prices for the services of their ancillary departments (OR, laboratory, radiology, physiotherapy, delivery room, etc.). Cost reimbursers usually pay the per diem rate for basic nursing and housing and supposedly cost-based charges for use of the ancillary departments. In practice, the finance office has considerable leeway in setting the charges for an ancillary department, such as the charge for a particular examination in radiology: estimating the costs of the entire department depend not only on the equipment, personnel, and supplies in it but also on the highly judgmental assignment of the costs of the hospital as a whole (such as administration, lighting, heat, etc.); within the department, costing and pricing each act is arbitrary. The finance officer has the great advantage over the third party because he alone understands its operations and books and because the Medicare-Medicaid laws and the Blue Cross contract guarantee his right to manage. Therefore, a common juggle is to identify an ancillary department used heavily by the subscribers of a cost-reimburser (for example, physiotherapy by Medicare; the delivery room by Blue Cross), assign many hospital costs to that department, and therefore collect high charges for that department from that particular third party. The charges for that department must be the same for all patients, but most users and the chief revenue will come from certain cost-reimbursers. Meanwhile, certain other widely used ancillary service may seem to have cheaper prices.<sup>18</sup> This is merely the modern version of the cross-subsidization and price discrimination that all hospital finance officers in the world once performed to balance their budgets. Organized payment systems with standardization of allowable costs -- as in all other countries and in several American states with rate regulation -- are designed to eliminate it.

Instead of welcoming and treating all patients on purely clinical grounds, hospital directors have strong incentives to find patients who can be charged for all items that other payers refuse. Many incentives

that theoretically operate for the hospital organization do not reach the directors and physicians and do not really affect the hospital's decisions, but the need to find charge-based patients definitely does. Hospitals seek out private patients, since they are self-payers, they have generous third party commercial insurance policies, or they can be billed for extras beyond the basic insurance coverage. The clinical staff as well as the business office has always been conscious of the patient's financial status in the past, and it still does. The charts include the admissions forms, with the reference to coverage.

If a hospital has few self-paying, commercially insured, and otherwise charge-based patients, it has financial problems. If it has no bad debts and little charity care, it can survive with economies. But it needs donors to buy the new equipment that retains enterprising medical staff. If the hospital has few charge-payers and many bad debts -- like hospitals in urban ghettos -- it can go bankrupt.

The system depends on concealment. Because of the juggling of books, the special deals with some third parties (especially Blue Cross), and the extra charges upon self-payers, few American hospitals publish all their rates openly. Hospital managers fear "losing business" not only because of high rates but because of the unflattering image from price discrimination.

The American Hospital Association opposes these variations among payers and favors a standard cost base. Then cost assignment is straightforward, prices are cost-based, and hospital finance officers are less devious. Likewise, independent state regulatory agencies favor standardization. (When the state Department of Health regulates hospital rates, it is less eager for standardization, since the strict Medicare cost allowances reduce its Medicaid liability.) In the name of testing regulatory programs, some state commissions have persuaded HCFA to waive the contractual allowances. HCFA is torn, since one statute obligates it to encourage state regulatory efforts while another (the Medicare-Medicaid law itself) mandates the limits on allowable costs. HCFA does not want to override the will of Congress by regulation or to pay out more federal money under more generous payment practices.

Negotiations to produce a waiver are difficult, because the complicated Medicare formulae must be harmonized with the often equally complicated state regulatory formulae. The many affected officials with HCFA share each other's worries about the disturbing precedents from any waivers. Meanwhile, months tick by and the hospitals are uncertain. If a waiver is finally given, the hospitals must understand and apply a usually complicated procedure, since Medicare never agrees completely to follow the state regulatory rules.<sup>19</sup> The waiver may be for only one year, and the state must repeatedly justify extensions. The Comptroller General has urged Congress to include in future legislation authority for "full participation" in state regulatory programs, presumably allowing Medicare and Medicaid to follow state rules.<sup>20</sup>

Evolution abroad. The public and private nonprofit hospitals originally were charitable, and users did not pay. Gradually users were charged, but relating the individual's rates to his actual costs was a late idea. Many persons in every country were billed according to their ability to pay. The richer apparently paid more than their personal costs -- often they were solicited for charitable donations as well as clinical charges -- but hospital accounts were not set up to calculate accurate costs per case or per patient day. The all-inclusive patient-day charge was a simple method of spreading the costs among many persons, as the number of payers increased.

As I said in Chapter III, European sick funds assumed the patient-day charges for steadily more of the hospitals' budgets. Governmental social welfare programs or private charities paid patient-days for many others -- a steadily declining proportion -- thereby relieving the hospital manager of the task of finding money to cover individual non-paying patients and relieving him of the need to transfer charges among those who paid.

As I said earlier, the Anglo-Saxon hospitals did not develop such an orderly payment system. Aggregate costs could not be averaged across several third-parties and self-payers accepting the same principles. Individuals only wanted to pay for themselves, for no-one else, and often not even that much. Third parties limited their obligations only to their own subscribers. The concept of "bad debt" arose:

someone who should have paid but didn't. Sliding scales by patients' ability to pay were common in hospital care as in private ambulatory medicine. Hospital managers became masters in juggling books, assigning charges regardless of costs, issuing public warnings about imminent bankruptcy to get donations and to justify their manipulations. Eventually Great Britain and Canada extricated themselves by aggregation of all costs and by government payment of global budgets. But the old system survives in the United States.

Current methods abroad. As in the United States, each fund might like to pay as little as possible and transfer particular categories of costs to the others. But the systems of rate determination prevent this. They are designed to standardize, put payers on the same basis, and avoid recrimination and surreptitious juggling of accounts. The theme of social solidarity -- central to the evolution of European health financing -- means that the sick funds should not play tricks on each other, that the hospital shall not play them against each other. The hospital submits to the regulatory body -- the COZ in Holland, the DDASS in France, the cantonal government in Switzerland, etc. -- a form specifying its costs incurred during the past year and expected during the next year. Whether certain items are allowable costs is decided as a fundamental policy at the highest levels, by the national leaderships of the hospital association, sick funds, and government. Often the decision is spelled out in an act of Parliament; or, it is a regulation issued by the Ministries of Health and Finance, as a definitive guide to all the regulators, negotiators, or grantors of money.<sup>21</sup> The decision about important allowable costs is never left to contracts negotiated bilaterally between sick funds and hospital associations. If items are not allowable, they are not included in the reporting form and therefore do not enter into the calculations.\*

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\*Hospital finance officers try to increase their rates and revenue in all countries, and the regulatory investigators must be alert that the cost reports do not include exaggerated or disallowed items. Depreciation is usually a limited fund for small items that the hospital buys itself; if so, it usually does not include the larger items donated by special public funds. The nursing staff lines in the cost report should not count personnel with lower ranks and lower salaries. Operating costs and personnel should not include new programs that have not

When the regulators set each hospital's rates, no distinctions are made among the payers. The arithmetic consists of dividing total expected costs for the year by total expected patient-days, without differentiating by the patient's sick fund or personal characteristics. The result is a charge that applies to every user of the hospital, both insured and self-paying. It is not possible to charge the self-payer more.

The rate is announced publicly, not concealed as in a hospital employing multiple-charge Robin-Hood methods. In many countries it is issued as a regulation over the signature of an official (such as a French prefect), and no user would agree to pay more.

In the one country where all hospital charges are set by negotiations rather than by a regulatory agency, West Germany, all the sick funds negotiate as a panel. They agree with the hospital on a standard daily charge, with no variations among carriers. Any self-payer in the basic ward pays the same rate. The negotiations take place on the basis of definitions of allowable costs developed in discussions among the national leaderships of the sick funds, the hospital association, and governments. The definitions and the reporting forms have long been spelled out in regulations issued by the national and provincial governments, viz., the national Bundespflegesatzverordnung, the Krankenhaus-Buchführungsverordnung, the Abgrenzungsverordnung, and the provincial regulations implementing them.<sup>23</sup> The price control office of the provincial government announces the rate. The result is exactly the same as if a regulatory agency had decided.

Since the European rate is standard for all payers, the hospital finance officer thinks of his budget as a single entity, with contributions from several sources. It does not seem a series of separate budgets for different payers. If the hospital as a whole is running a serious deficit, he may seek an emergency increase in rates, before the

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been approved by planners. A teaching hospital's operating costs for patient care should not include the salaries of researchers, for faculty members,<sup>22</sup> and secretaries who should be paid by the Ministry of Education. Besides some disallowances, the investigators make most of their cuts in personnel and operating costs that exceed the relations to expected utilization, according to the guidelines.

next regular annual review. Since revenue flow is simpler and more predictable, the European hospital finance officer is better able to judge than the American when he is going into deficit. He tries to change the rates less often during the year.

A fundamental issue is whether last year's deficit is an allowable cost in the next year's prospective budget. In some countries, the forms for last year's expenditures and the new year's prospective budget are combined; deficits and surpluses are carried over. Once the regulators approve and carry over the deficit, it is covered by extra revenue in the new daily charges, so the hospital can pay off the short-term debt. In Holland, the extra money comes from a temporary surcharge, eliminated from the daily rate when the debt is liquidated. In France, the money is spread among all payers over the year, so that the daily rate is slightly over current operating costs. The regulators thereby tell someone else (the sick funds) to pay off a debt they deem legitimate. Hospitals are more likely to overspend, since the system presumes that a justifiable deficit can be covered.<sup>24</sup> In theory, surpluses should be carried over and recaptured through lower daily rates than would be justified by operating costs, but they are less common than deficits.

In countries where the payers face the hospitals directly, they can enforce their distaste for covering the hospitals' overspending. The prospective budget forms are distinct from the end-of-the-year expenditure reports and lack any space to report deficits. The rates are set prospectively on the basis of operating costs alone. If it runs a deficit during the year, the hospital cannot appeal to a neutral regulator for a higher rate and cannot count on his sympathy next year, but it must make a special request to the payer. The payer is likely to plead poverty and advise cutbacks in personnel. German sick funds have never recognized previous deficits as allowable costs. Canadian provinces have not included such carryovers in prospective budgets either; once they were generous in granting supplements during the year, but not recently.<sup>25</sup>

On later pages, I will describe how foreign payment systems handle certain items that are controversial in the United States, such as bad debts, investments, and teaching.

## CHARITY AND BAD DEBTS

Issue. Two of the most troublesome elements in American hospital payment are intentional free care (i.e., charity planned in advance) and unpaid bills (i.e., accounts receivable that are ultimately written off as bad debts). In both cases, the hospital has incurred costs in treating patients, but these patients bring in no revenue.

An oddity in American hospital finance is that many (not all) hospitals are required to give some "free care," if they ever received grants from the Hospital Construction (Hill-Burton) Act. In practice, the patients who are not billed constitute between 3 and 5 per cent of total number of admissions, a substantial figure. American hospitals had always treated nonpaying patients, particularly in the poor neighborhoods where Hill-Burton was designed to improve services. At the time the regulation mandating some free care was adopted in 1972, policy-makers were concerned that the government's grants program (begun in 1948) was building too many affluent installations that were catering to a middle class clientele by excluding the very poor. Hill-Burton grantees were thereby required to keep their indigents. Another policy problem supposedly remedied by the condition was the discovery that Medicare and Medicaid were incomplete. Many of the poor still were not covered by anything.

The regulation was based on the traditional American image that it was the hospital that found the money for care. But during intervening years, financial planning had become the responsibility of patients and insurers.

At the same time, all hospitals -- including those without the Hill-Burton obligation -- had some bad debts. If the hospital had not yet used up its quota for charity cases, it could count in the bad debts. Often it had both free cases and bad debts.

Not all unpaid bills are left by the poor. Quite a few are for patients' shares of costs, otherwise covered by third parties. Hospital business offices have so much work and so many pieces of paper, that they cannot pursue everything. Collecting a delinquent small account is too expensive. Sending a collection agency after a patient is bad public relations.

The American hospital -- like the British and Canadian hospitals before they abandoned patchwork financing -- has been left with the task of covering the costs for the non-payers, either by gifts from donors or by overloading the bills of the payers. But while one law of the national government mandated charity, another made it difficult for the hospital to pay for it. Medicare and Medicaid would pay only for the costs of their subscribers, not help the hospital pay for anyone else. Neither would count the hospital's charity account as an allowable cost; Medicaid would not share in the bad debts of anyone, except in the few states where Medicaid patients had charges and some failed to pay them; Medicare would pay only for the cost-sharing by Medicare patients that they failed to pay either out-of-pocket or by supplementary insurance policies.

Since Blue Cross has been committed to helping the hospitals balance their budgets, most Plans agree to share in all charity care and bad debts, regardless of source. However, some Plans pay only for the unpaid bills of Blue Cross subscribers.

Evolution abroad. As I have said, once nonprofit hospitals in Europe and North America were charities. Most patients were indigents and paid nothing, although they often had to surrender some of their property. The principal financial task of the managers and owners was to find money.

By the 1950's, national health insurance in Europe had eliminated the need for charity by all employed and self-employed persons and their families. The method of all-inclusive per diem rate made clear what each person was expected to pay -- either personally or on his behalf -- to cover his expenses in full. The rich could pay themselves or buy private insurance. Some medical indigents still existed: the elderly who had never built up NHI coverage; rural workers; poor urban workers whose employers were not covered by NHI; unemployed; immigrants. Local governments in Europe provided social welfare, and most programs paid for hospitalization of their poor residents by the standard per diem rate. But this strained local budgets.

The financing model for the general population had been NHI, and it was extended to the medically indigent in several countries, such as France. One method (as in France) was to enroll every citizen in an

established sick fund. Those who had never paid premiums strained the finances of the sick funds until the national government started to give general revenue grants each year to the carriers, in lieu of premium income. In The Netherlands, retired persons pay thirty per cent or less than the normal premium according to their incomes, and the government's subsidy pays the rest. An additional Dutch insurance program (AWBZ) pays for extended hospitalization beyond the shorter stays covered by NHI; it is paid for by a payroll tax on employers and general revenue from the Dutch government. The special AWBZ accounts are administered by the established Dutch sick funds, thereby coordinating the benefits. Assimilating the elderly and indigent into the established health insurance system in Europe guarantees them the same benefits as other patients and the same status in the eyes of hospital staffs.

If NHI seems to have reached limits, some countries opt for completely public financing, without insurance mechanisms. All citizens have a right to medical care, regardless of income, employment, and age. All hospitals are paid in full from general revenue. No-one is "medically indigent" and there can be no "bad debts." Examples of such Treasury financing are Great Britain, Canada, and Italy. In Britain and Canada, under earlier NHI or private arrangements, large numbers of persons were not insured; and in all three, subscribers had greatly unequal benefits.

No country has anything like the Hill-Burton condition, requiring that the hospital give care without billing those patients. The history of hospital payment abroad has been the progressive elimination of collection problems, so that the manager and governing board can cease fund-raising and concentrate on managing services.

Current methods abroad. When a patient is admitted to a European or Canadian hospital, the business office acts quickly to make sure that he will not leave unpaid bills. The procedure is much like the preadmission and admission methods in the United States. If the patient shows a membership card in one of the sick funds that ordinarily pay the hospital directly, the hospital sends a form asking whether the patient is a subscriber and whether the sick fund guarantees payment in full for that case. The exchange of papers takes only a few days, since it is routine and since the hospital must know the answer quickly. In some countries,

such as Germany, some or all sick funds approve a stay for a certain number of days and expect to be asked for a reauthorization if the patient is kept longer.

If the patient is not guaranteed by a sick fund, the hospital may ask a cash deposit, sufficient to cover the first week at the current daily rate. If the patient has already been admitted and a sick fund has refused a guarantee, the patient's family is asked to provide the guarantee. In such cases, delays may occur, and the hospital tries to collect the bill in full on discharge. Hospitals ask patients to renew their deposits when they are used up, such as after the first week.

If the patient is not covered by a sick fund and is financially unable to provide a deposit, the hospital asks the social welfare office of the local government for a guarantee. Once a principal payer, these programs for indigents have lost their predominant shares of health payment to the sick funds. If the patient is already registered with the welfare office for other benefits, the guarantee comes automatically. Hospitals try to get the guarantee from the welfare office before admission, so they won't have bad debts, but emergency admissions must be checked later.

In a country with full Treasury financing, such as Great Britain, every resident is covered in full. Therefore, only foreigners might require a guarantee from a carrier or a deposit. In a federal system like Canada, the hospital can bill the provincial government only for care of its residents. Therefore, the hospital's business office must quickly learn the addresses of any out-of-province patients. Coverage is usually automatic, but the hospital must look up the other province's benefits schedule. The hospital may be more expensive, the other province may only pay at its customary lower rates, and the hospital warns the patient of a bill for the difference.

As a result, Europe and Canada have a few cases that slip through the cracks and leave unpaid bills. Some are foreigners who leave the country. If the hospitals are paid in large part by government money (as in Switzerland), or if government administers the sick funds as part of social security (as in France), the national or provincial governments ask those countries' embassies to pay. Usually this has limited success,

but the foreign governments (such as Algeria, Turkey, and other big suppliers of migrant workers) are embarrassed when the hospital association or the provincial government leaks the total of all unpaid bills to the newspapers.

As a result of all these arrangements, the total of unpaid bills is very small, even under national health insurance. For example, during 1978, the total operating expenditures of French public hospitals outside Paris were 51,549,165,000 F. The total bad debts (créances irrécouvrables) were only 7,521,000 F., over half of them in the big urban teaching hospitals.<sup>26</sup> The bad debts are counted as a loss in the expenditure account, thereby adding to the year's deficit or reducing the year's surplus. The deficits and surpluses are carried over into the next calculation of a daily charge. There is no way to differentiate liability for bad debts among the payers. The bad debts are made up in the daily rates that everyone pays.

#### PAYMENT IN FULL

Medicare limits. Having agreed to pay costs, some American payers refuse to pay all costs automatically. Believing that an unqualified commitment to reimburse costs would encourage runaway profiteering by hospitals, the Congress in the original Medicare law and in the 1972 amendments authorized the Secretary of HEW (later HHS) to apply exclusions and limits (Social Security Act, Sec. 1861(v)(1)(A)).

One target in American cost containment thinking has been the very expensive provider. By refusing to pay their excessive costs, class averages will be constrained from rising quickly and the pacemakers will not be allowed to set bad examples. These so-called Sec. 223 limits are placed on basic care costs, i.e., the daily rate for routine care, other than ancillary services. The hospital must be warned whether its probable costs will exceed the limit; its interim Medicare rates must be within the limit, and it is entitled to charge the patient for the extra amount or to shift the unreimbursed costs to charge-payers. The hospital is assigned to a peer group (defined by size and location), the peer group averages are calculated from the best available expenditure reports, and

the peer group averages are trended forward into the coming year by several inflation factors for wages and hospital costs. The upper limit for Medicare reimbursement is a percentage that varies according to the government's strategies and political prudence, such as 112 per cent during 1980-1981 and 108 per cent during 1981-1982. HCFA issues the methodology by regulation, but Congress usually makes the delicate decision on the percentage of the mean.<sup>27</sup>

Hospitals criticize the method as a penalty for the efficiency that the government claims to encourage. The establishment with the highest daily costs may be the ones with the shorter stays, greater service intensity, and lower costs per admission. HCFA's response has been to add refinements -- and complications -- to the methodology, to avoid squeezing the more efficient. Other calculations exempt other special situations that might yield political heat and lawsuits. As in all automatic American formulae, the methodology becomes complicated and difficult to understand.

Some critics say that the Medicare ceiling reflects an antiquated conception of hospital care and controls the wrong thing. The source of proliferating services and costs -- some unnecessary clinically, but profitable financially -- is the ancillary departments. But Medicare pays ancillary charges in full. An expensive hospital can appear to stay within the limit by debundling basic care and charging for some items under ancillary services.<sup>28</sup> This is another example of how the fragmented American payment system and the absence of standard accounting and rate-making encourage manipulation of the books. Management prerogative results in different financial practices among hospitals and results in changes within each hospital that have nothing to do with the rendering of services.

The limits are a Medicare penalty and not a ceiling on the hospital's total expenditure. The financial officer merely shifts the costs elsewhere, usually to the charged-based payers. Therefore, they pay a share of the Medicare patients' costs.

Blue Cross discounts. A charge-based system usually gives the initiative to the hospital: it sets rates for everyone to pay. But a large purchaser, like Blue Cross, can negotiate a discount. Some Plans

obtain concessions from participating hospitals, not only because of their friendly relations but because they provide important advantages. The hospitals are saved large collection costs because of Blue Cross' prompt and direct payment, because few subscribers run up bad debts. Of 39 charge-based contracts in 1979, 10 Plans paid only 94 per cent to 98 per cent of the hospitals' charges. Such discounts once were more common.<sup>29</sup>

A cost-based reimburser can achieve the same special reduction by convincing the hospital that it burdens the business office less than other payers. So, lower administrative costs are attributed to Blue Cross during the cost-finding.

Costs of all sorts not covered by Medicare, Medicaid, and Blue Cross are loaded onto the charge payers. HIAA complains that, in those states where Blue Cross Plans pay costs, its payments are 16 per cent below the charges.<sup>30</sup> But service industries often negotiate special deals with different customers in America's business markets and the courts have upheld Blue Cross's differentials as reasonable economic behavior free from coercion.<sup>31</sup>

Current methods abroad. The Medicare ceilings and Blue Cross discounts are peculiar to the fluid situation of the United States, anomalies arising from America's treatment of hospital care as a typical market for business services. They are impossible in any other developed country, where payments are standardized. When a rate is set by regulation or negotiation, every payer pays it in full. The hospital does not forego collection in full from everyone.

Standardization of this sort is favored by American state regulators, since it gives the hospital no incentive to manipulate the books and overcharge the charge payers. The commissions in Maryland and Washington have gotten Medicare-Medicaid waivers to recognize nearly the same basic cost base and have reduced the Blue Cross discounts.

Like HCFA, foreign regulators and negotiators want to damp down the increases among the most expensive hospitals. They too make peer group comparisons of the prospective budgets and expenditure reports. And they too often cut the daily rates requested by the exceptionally high hospitals. The decision is made not automatically by the computer,

but by examiners after a full investigation and discussion with the hospital. If a rate is reduced, the hospital is not allowed to charge any patients the difference; the new rate is final for everyone. The hospital is expected to work more parsimoniously than it had planned.

#### INCENTIVE REIMBURSEMENT

The foregoing method of restraining costs takes money away from the wasteful. A positive stimulus is to give money to the thrifty and efficient. Those who save money might keep it.

Issue. The enactment of Medicare and Medicaid during the mid-1960's and the expansion of Blue Cross seemed to eliminate all financial self-discipline from hospitals. They were now guaranteed all costs in full for most patients, apparently no matter how high. Hospitals were still considered private, rate regulation had not yet been created in state governments, Washington had not yet begun its detailed investigations of hospitals and nursing homes, and the problem was to inspire American hospitals to be as self-disciplined and thrifty as they supposedly had been before.

Faithful to the models of "free markets" and accustomed to discuss hospitals in the vocabulary of the economics of firms, some reformers proposed that hospitals should be paid and rewarded somewhat like business firms. Each hospital would receive a charge schedule or a global budget at the start of the year, and the schedule or budget would not change. The hospital could then manage its resources in the manner it considered most efficient. At the end of the fiscal year, the hospital could keep any savings. If it incurred any losses, the hospital -- and not the payers -- would cover them. Blue Cross welcomed these proposals, as a method of stopping the sudden and recent increase in hospital bills. Hospital managers favored the proposals, because they would retain discretion.

During the late 1960's and early 1970's, many incentive reimbursement experiments spread throughout the country, often for the payment of Blue Cross patients. Incentive methods seemed a natural element in prospective reimbursement. End-of-the-year settlements were

needed in retrospective reimbursement but would not be used in prospective reimbursement. The first state government rate regulation programs in New York and Connecticut used incentive reimbursement.

Difficulties. The early schemes failed to restrain costs and failed to inspire managers to become conservative and thrifty. The offer of incentives did not induce hospitals to underspend for several reasons: the hospital is not as unified as a business firm, and the manager controls only a few programs; the many independent actions of doctors and others are difficult to track and modify; the possible objects of expenditure by the director from savings are less interesting personally to doctors than performing clinical work with the newest methods; reducing spending in one year results in permanent reduction of the hospital's budget base; the gains from saving are far less than the gains from overspending and overcharging.<sup>32</sup>

The theory behind incentive reimbursement assumed that behavior responded to the balance sheet, defined as a continuous variable, as in business. But while hospitals did not strive to earn profits, they did strive to avoid losses. While a profit could not be used as a reward, a loss was definitely a difficulty. So, the theory was half-right.

But the goal had been voluntary incentives to reduce expenditure through greater efficiency. This had not been found in acute hospitals, state governments began to adopt rate regulation, and Blue Cross became a tougher bargainer. A few regulatory agencies still try to motivate hospitals to save money by formulae allowing them to keep some of the savings.<sup>33</sup> But this is possible only if all the payers agree.

In the related field of nursing homes, incentive reimbursement took root, but the lessons were never mentioned in the still hopeful literature about incentive reimbursement in acute hospitals. The businessmen who flocked into the nursing home "industry" during the late 1960's and early 1970's demonstrated how to run disciplined establishments and how to make incentive reimbursement "work." Nursing homes in many states set per diem and itemized charges; the amounts were paid (by Medicaid, Medicare, and self-payers); nursing homes economized on food, personnel, safety, and supplies; owners pocketed the profits. Owners used their market position through bulk purchasing to obtain lower prices

or commissions (sometimes called "kickbacks") from pharmacies and funeral homes. Some fitted their nursing homes into speculative businesses in other fields, taking advantage of tax laws and laws for the benefit of nonprofit enterprises, to produce large gains in profits and in equity together. If such an owner had delivered a satisfactory product with steadily greater profit margins in any other business, he would have been congratulated. If his product was inferior, he would be sanctioned by gradual loss of customers, law-suits to recover payments, and law-suits to replace defective merchandise.

Charge-based reimbursement provided opportunities to underserve and profiteer. Reforms of nursing home care under Medicaid during the early 1960's introduced cost-based reimbursement of nursing homes, as in the payment of acute hospitals under Medicaid and Medicare. In theory, nursing homes would be guaranteed enough money to give their patients all necessary food, medications, comforts, and personnel; and owners could not withhold any money for themselves. A mentality that could exploit patients and payers under charging could try to plan even more tricks under cost reimbursement: owners and managers bought things for themselves and mixed the invoices in with the establishments'. It is difficult enough for the Medicare fiscal intermediaries to validate costs listed by the acute hospitals, and the state Medicaid agencies lacked the personnel and methodology to do the same for nursing homes.<sup>34</sup>

Charge-based reimbursement -- whether in health or in any other sector -- exempts the provider from close scrutiny by payers and (usually) by public agencies. Customers, suppliers, stockholders, and tax collectors are the ones who are hoodwinked by sharp practices in private business. Often they don't know about underserving; if they do and are dissatisfied, the usual market solution is to change to a competitor. The profiteers in nursing homes had the advantage that the customers who experienced underservicing were often inarticulate and not fully in control of payment; the payers (family, insurance carriers, and government) had a limited understanding of the services and were motivated not to change to better and more expensive competitors. If a provider in business can get away with sharp practices, not antagonize his customers and suppliers, and earn high profits, he is admired. Such persons in

nursing home care could see nothing wrong in running their businesses the same way, as, indeed, some had done earlier outside health. Under a cost reimbursement system, whereby the government prescribes allowable costs of giving care to patients, these practices were not a legitimate discretionary allocation of profits but were fraudulent. The operators had not separated their accounts clearly enough.\*

Evolution abroad. A self-regulating payment method is the Holy Grail of hospital finance. European policy-makers dream of it too. Hospital managers like the idea of some free money. They have read about American incentive reimbursement proposals. But no such schemes have ever been attempted on a substantial scale, and very few experiments are attempted.

Current methods abroad. As long as hospitals were charities with deficits, saving and using discretionary money was moot. As national health insurance and government grants spread, hospitals were paid in full from public money, viz., premiums levied by payroll taxes and distributed by sick funds and/or general revenue. For public money, the problem in every country has been full accountability to prevent fraud and underserving. Any money not spent must be explained. It should be recaptured by the premium-payers and tax-payers, since presumably it was allocated by error: the provider did not need the money to complete its work; if the savings occurred in variable costs due to utilization lower than predicted, the provider certainly should not get a windfall. Both in regulated and negotiated rates, the principle has been reimbursement of costs: in nearly every country, a reconciliation step at the end of the year investigates the hospital's accounts, carries over savings to next year, and pays justifiable deficits.

It is unusual abroad, but a country might not have an end-of-the-year settlement. Really it would be a prospective system of controlled charges. One of the few examples is Germany. Neither deficits nor savings are carried over into the next year. The method has long been

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\*Many of the supposedly fraudulent actions are common in places both high and low in American business, including charge-earning proprietary hospitals, viz., diverting the firm's gross income into one's own pocket as salary, bonuses, profits, or expense accounts; personal use of objects and services listed as company property.

intended by the sick funds to force the hospitals to live within the limits and not count on supplements. Savings are unusual and result primarily from a decline in utilization. The manager has considerable discretion in using the savings, but usually he uses it up during the year through reallocations or by paying off last year's deficit, without ending the current year in surplus. By using up the savings quickly, he can benefit, but he postpones tipping off the sick funds that his utilization was declining and that his budget should be permanently reduced.

Under a cost reimbursement system, a hospital can run surpluses for several years, if the regulators or the payers review the accounts by exception. This is unusual, but it occurs in Holland. A hospital is not required to submit full application for a new rate every year. If last year's was satisfactory, the hospital keeps it, trended upward by the inflation factor applying to everyone. Therefore, the hospital manager can keep, reallocate, and even invest any savings for one or more years. If a hospital submits no new application papers to COZ for several years, COZ investigates, since it suspects the hospital might be skimping services or earning a profit by multiplying patient-days and tests. The hospital might eventually have to surrender prolonged net profits back to the sick funds.<sup>36</sup>

At present, several hundred French public hospitals are experimenting with new payment methods. One devised by the national hospital association (the Fédération Hospitalière de France) includes incentive reimbursement. If the hospital saves money from greater efficiency -- i.e., patient-days are fewer than originally planned for the same number of admissions, and spending has dropped more than income -- the savings go into a special fund. The director may spend the fund for the hospital, with the approval of the prefecture. The health officials of the prefecture oversee the hospital's rates and requests for investment loans and therefore can judge whether the director's proposal conforms to the hospital's priorities. Rate regulators and planners do not want the hospital director to perform an end run and quietly spend savings on items they had previously disapproved. Otherwise, in the future they might be presented with requests for higher operating budgets and higher daily rates, which they had earlier tried to prevent.<sup>37</sup>

Incentive reimbursement schemes have reverse incentives: the savings reveal the hospital needed less money, regulators reduce the base in future years, the hospital in the long run loses more than it keeps the first year, and therefore the director avoids reporting a saving. When Americans were experimenting with incentive reimbursement, Ontario did too. If a hospital saved money and expected the savings to be permanent, it kept 90 per cent of that year's savings; but next year's budget was reduced to the expenditure level. If a hospital saved money and expected the savings to be temporary it kept 10 per cent of that year's savings; and next year's prospective budget remained the same. Both methods failed. Very few hospitals reported permanent savings; suffering a permanent reduction was a powerful disincentive. Few hospitals saved even temporarily, since 10 per cent was too small to reward a dislocation in work. All hospital managers preferred to grow.<sup>38</sup>

Ontario's solution has been abandonment of all incentive reimbursement schemes: the province's global budget is now supposed to be enough for the hospital's work, and surpluses revert to the Treasury. Negative incentives exist against overspending, and no positive financial incentives are offered. Quebec still seeks an incentive system that does not trigger the hospital managers' fears that any savings will result in permanent budget reductions. The newest method in Quebec involves extensive peer group comparisons to distinguish among types of saver. The payment system's rules decide the vexing matter of when a saving is rewarded both in the short and long run, when it leads to a permanent reduction in the base. A saver with reduced utilization gets a lower base next year; savers with constant or even higher utilization under some conditions retain or expand their bases.<sup>39</sup>

The usual image of incentive reimbursement in the United States is inspired by business: at the end of a year, the manager through greater efficiency shows an unexpected profit and can use it as he likes. Government agencies are thought never to allow such behavior; unspent money goes back to the Treasury; underspending agencies lose part of their budgets next time; government agencies therefore "get rid of" money at the close of the fiscal year instead of saving it; a successful agency head is one with a growth in activity and money. At first sight, it

appears as if all nonprofit and public hospitals behave this way, and that incentive reimbursement can be practiced only within the small and unusual proprietary sector. And there it can have perverse effects.

Despite the image of the public sector as inherently spendthrift and without economizing incentives, the manager can be induced to save provided that he can reallocate. Given a global budget, much discretion, and enough authority, he may squeeze funds out of obsolete and lower priority activities in order to save or expand newer and higher priority activities that will bring his organization and him more prestige. Managers in the National Health Service of Great Britain have imposed more economies and more changes than managers working under incentive reimbursement schemes. Within the NHS, every unit has a long-range strategic plan, a short-range implementation plan, and an annual budget. The management team (for example, the DMT of a District Health Authority) is supposed to manage and spend in order to achieve the coming year's plan. Many districts experience sweeping reallocations, from intramural to extramural services or from older to newer installations. Often a management team underspends for a hospital by closing it down at a pace faster than expected, in order to carry over the money to the next year, when a replacement starts up.

If a country is organized under vertical and hierarchical budgeting, such compensating savings and reallocations can be performed among districts. Higher officials in the Regional Health Authorities (RHA's) of the NHS are supposed to oversee the lower tiers. They do not merely look at "bottom lines" in financial accounts but need to know how they were achieved and how they will evolve in the future. Until 1980, the responsible financial authority consisted of several areas within each region (Area Health Authorities or AHA's) and the management units were the districts (then called District Management Teams or DMT's). An AHA with a deficit-ridden DMT (often one with a teaching hospital) might try to calm the RHA by pointing to off-setting surpluses in other DMT's, by implying that utilization was shifting. The RHA would have to understand whether this was true or whether the DMT's were running only temporary surpluses, saving for next year's new programs. If the change was a temporary reallocation, the entire area would soon have a serious deficit.

(To enable the RHA's to monitor the DMT's more closely -- among other reasons -- the AHA's were abolished during 1981. Perhaps the RHA's will retain the power to force savings in one district and to relocate to another.)<sup>40</sup>

#### LESSONS FOR THE UNITED STATES

Costs v. charges. Ultimately the two principles of payment coalesce.

1. "Charges" are normal in commercial activities, customers are accustomed to paying in variable ways to satisfy their wants, producers price flexibly to cover their costs and gain surpluses for profit and reinvestment, prices change frequently to take advantage of strong demand or to attract new customers. A business firm offers many products or services, it charges for each, the charges have different relations to costs, and it is the total that counts.
2. However, patients and third party payers resist charge-based payment not merely because charges are high but because of the basic principle. Hospitals are considered social services, once charities affiliated with churches. Hospitals are supposed to be owned and managed as public trusts. Extra money beyond what is needed to cure the sick is not supposed to be appropriated by anyone (whether carrier or provider) but is supposed to go back to the donors and subscribers. Hospitals and sick funds are expected to account for their services and finances; charging customers in simple ways, using the money according to one's best judgment, and keeping all the decisions within a small circle are management prerogatives not compatible with full public accountability. Reimbursement of costs is the principle upon which providers and payers can converge.
3. Charges might still survive in medically related work that gratifies persons' desires beyond basic medical care. I.e., the more attractive providers ask what they want, patients go where they like and where they can afford the fees, and third parties are involved very little. Examples are cosmetic surgery, orthodontics, rest cures, physiotherapy, psychiatry, some care of the elderly, abortions. Charges can apply to extra services in hospitals.

4. Physicians have been able to resist cost-based reimbursement and collect both practice costs and personal income in their fees. However, payment systems abroad have nearly eliminated physicians' discretion to set their charges and seem to be pressing on the honoraria. Negotiators often try to base paying the doctor on cost-plus, but estimating average practice costs for all doctors is elusive. So, the negotiators settle on informed guesses.
5. Detailed estimates of operating costs in each individual hospital are the common basis for paying them. Reimbursement of costs is the compromise between payers and providers. Historically, hospitals struggled to recover costs from patients and third parties, thereby relieving themselves of previously incessant charity drives, but nonprofits could not make a case for revenue above costs. Third party payers resist paying more and seek full explanations.
6. In the rare cases of charge-based hospital payment by a third party for basic medical care abroad, eventually charges are "controlled." The payer scrutinizes the hospital's case and bargains over the charge schedule. Charges remain stable, in accordance with a general belief that the hospital should be a stable organization. Charges are not frequently changed, as a business firm does.

Retrospective v. prospective payment. Ultimately cost-based reimbursement becomes prospective, with retrospective settlements of deficits and overpayments. If payers and hospitals presume that the hospital should operate within the prospective budget and the first interim rate, costs can be contained. Thus cost-based reimbursement can be administered somewhat like global budgeting.

Carrying over deficits from one year into the allowable costs of the next is an invitation to overspend. Carrying over surpluses from one year into the offset revenue of the next is an incentive to undersave. Greater financial discipline probably results from separating the end-of-the-year settlement and the fixing of prospective rates.

Careful prospective budgeting must be done for utilization as well as for expenditure. Since the case for higher settlements is usually based on utilization increases, the regulators or negotiators must have historical baselines and guidelines about utilization.

Strict regulatory agencies need to understand the internal affairs of individual hospitals. Auditors and liaison officers get to know the hospitals. Therefore, when they propose cuts and when the hospitals object, the auditor understands better what he is doing.

Wide differences among third parties in what they will pay produce rivalry and concealment among them and overcharging of the weaker bargainers. Hospital managers are diverted from managing services to juggling books and finding money. The uncertainties can lead to over-pricing and overexpenditure, not to cost containment.

Regulators try to eliminate price discrimination among payers, cross-subsidization among revenue centers within the hospital, and manipulation of the books. They try to standardize costs and prices among all payers. If the weaker and overcharged payers cannot obtain equal treatment by legislation or by collective negotiations, they become an important political force favoring reform by standing regulation.

Limits do not automatically limit. Hospital managers and doctors must be willing to cooperate. Simple rules are more effective than complicated ones with ambiguities and loopholes. If the payment system encourages the payers to compete with each other in manipulation of loopholes, each will tacitly invite the hospital to discriminate in their favor at someone else's expense. The result may be more expensive for the system as a whole.

Bad debts can be eliminated almost completely by an orderly payment system. But this presumes an orderly society, wherein all inhabitants are registered in programs.

Incentive reimbursement:

1. None of the key participants really want incentive reimbursement schemes:
  - (a) Hospitals refuse to take the bait, if savings demonstrate the ability to do the same work for less, and if next year's budget will be reduced accordingly. But this is precisely what incentive reimbursement is intended to do.
  - (b) A hospital is a long-range operation. Much of the "economic" behavior of the director is concerned with his long-range budget and revenue expectations. He will take only short-term

actions that are compatible. Incentive reimbursement theory projects onto the hospital director assumptions about immediate pecuniary gratification that are not even true for more than a few business firms.

- (c) Motivating the hospital director is not enough. The doctors must be involved. They often are not reached by third party incentives addressed to the administrators. In fact, they might lose, and they will not cooperate.
  - (d) Unions will block any economies at the expense of wages and jobs of incumbents. They gain only by large annual increases in wages.
  - (e) Third-party payers (sick funds and governments) want their money back, if it is not used for patient care. They don't want to "give" it for discretionary activities selected by hospital managers, which the "rightful owners" of the money consider unworthy. Government is often legally unable to allow private actors to keep "extra" money, except for specifically authorized purposes.
2. Hospital managers can react to negative incentives, if not to positive cash incentives. They fear unreimbursed deficits as well as reductions of their budget bases. Therefore prospective reimbursement without an end-of-the-year settlement or without a carryover into the next prospective budget persuades them to avoid deficits. They may be motivated to save money, but only if they have discretion to reallocate it to other worthy purposes.
  3. Incentive reimbursement schemes usually require that hospitals use the savings for high-priority matters, approved by the payers. Therefore, in practice they are not so different from the simple right of managers to reallocate their revenue during the year, cutting certain programs and expanding others.
  4. The usual incentive reimbursement scheme is derived from conservative market economics. This ideology argues that the best (most "efficient") organizations and individuals are those that earn a profit from their earnings, over the costs incurred to produce their output. But this idea is not the way to evaluate a hospital. A hospital must

be judged by other standards. A good hospital may sometimes earn a "profit," at other times not. There are many reasons to question the quality of a hospital that repeatedly earns a "profit." Reciprocally, incurring a deficit by itself does not measure the quality of a hospital.

5. If money rewards are to be used to reward efficiency and quality, they must be disengaged from the expenditure-budget cycle. Unlike "profits," they should be beyond the capacity of the hospital to generate for itself from its own revenue. The money rewards should come from a special fund and should be awards for excellence, given by a commission of leaders in health and financial affairs. They would be annual or short-run analogues of the distinction awards given to British consultants.\* They would not be self-generated by the hospital -- i.e., the hospital's savings would not automatically be its own reward, because that procedure is an incentive to under-serve or (probably more often) to transfer costs to other payers, and because self-generated savings are an advertisement for potential budget-cutting. The real goal of hospital work and of hospital finance is better (not always cheaper) care, and this is the true object of distinction awards.
6. Extensive regulation of the payment of hospitals cannot be avoided; if the hospital is allowed to save money, surveillance and regulation are needed to protect the quality of care. Serious medical care is not like buying a dishwasher: one can be stung with a poor dishwasher, survive the loss of money and efficiency, return it for repairs, or buy a better dishwasher next time; but since poor

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\*A special committee investigates the performance of senior hospital doctors, by interviewing their colleagues and NHS officials and by examining indicators of their work, such as publications. Every year they give "distinction awards" of different financial value, which doctors receive as supplements to their basic salaries until retirement. One-third of the consultants hold awards: a few receive large ones, many receive smaller ones. Once many were in large teaching hospitals, but recently the committee has tried to identify worthy careers in ordinary hospital medicine throughout the country. Thus merit is not measured from high earnings that the consultant himself generates,<sup>41</sup> but higher earnings result from professional judgments about merit.

medical care has irreversible and serious consequences, society cannot say "caveat emptor." If government is not the organized overseer of health care to protect the consumer, powerful private organizations will be created to play the role. When money is at stake, the sick funds may form coalitions with the providers to save money. Therefore insurance carriers cannot be fully trusted to be the consumer's watchdog to protect the quality of care.\*

7. Incentive reimbursement schemes derive from managerialist reasoning. They assume the hospital management makes the savings and has the exclusive right to use them. However, a few foreign countries (such as Britain) already have labor contracts with productivity bonuses for certain hospital workers. If hospitals on a large scale receive rewards for saving, unions will insist on a voice in their disposition. Unless he and the unions can agree, little discretionary money will be left to the manager.<sup>42</sup> His life will be more rewarding if he does not try to squeeze savings from the doctors and the workers.
8. Any innovation can be undone because many other things are going on in health care financing at the same time. An incentive reimbursement scheme requires an environment controlled to an unrealistic degree. Governments may act in ways that expectedly cancel out the effect of the incentive scheme, such as changing the base for budgetary revision or imposing a severe expenditure ceiling that creates widespread deficits.

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\*If an organization is both insurer and provider -- as in the case of the American HMO -- its incentives are directed at financial control, rather than quality. The incentives discourage overtreatment, and the problem is to guard against undertreatment.

## FOOTNOTES

1. Irwin Wolkstein, "The Legislative History of Hospital Cost Reimbursement," in Reimbursement Incentives for Hospital and Medical Care: Objectives and Alternatives (Washington: Office of Research and Statistics, Social Security Administration, U.S. Department of Health, Education, and Welfare, 1968), Ch. I.

2. Described in successive editions of the Medicare Provider Reimbursement Manual. The history of the restrictive payment rules -- and the attempts to undo them -- is in Judith M. Feder, Medicare: The Politics of Federal Hospital Insurance (Lexington, Mass.: Lexington Books, D.C. Heath and Company, 1977).

3. The many Blue Cross prospective reimbursement negotiating arrangements installed during the 1970's are described in the special issue of Topics in Health Care Financing, Volume 3 (Winter 1976); in William L. Dowling, "Prospective Reimbursement of Hospitals," Inquiry, Volume XI (September 1974); and in a series of reports by Arthur D. Little, Inc., 1974.

4. The steadily increasing intervention by national and state governments to restrain the inflationary effects of the statutory wording is summarized in Stephen M. Weiner, "'Reasonable Cost' Reimbursement for Inpatient Hospital Services under Medicare and Medicaid: The Emergence of Public Control," American Journal of Law and Medicine, Volume 3, Number 1, pp. 1-47.

5. The commercial carriers' critique of the differentials and estimates of their additional burdens appear in many issues of the HIAA newsletter, "Report on Consumer and Professional Relations: Hospital Relations" (New York: Health Insurance Association of America, especially 12 February 1981, 26 August 1981, and a third to be released in early 1982).

6. For example, Katharine G. Bauer and Arva Rosenfeld Clark, "The Indiana Controlled Charges System" (Boston: Harvard Center for Community Health and Medical Care, 1974). Blue Cross in Indiana does not drive a hard bargain and shift hospital costs to other payers. The negotiated charges apply to all.

7. One element in the National Health Care Reform Act of 1981 (Gephardt-Stockman Bill, H.R. 850). Described in articles in Hospitals, 1 October 1980, pp. 58-61; and Modern Healthcare, June 1980, pp. 32-39 *passim*.

8. Described in Glaser, Paying the Doctor (Baltimore: The Johns Hopkins Press, 1970); and Glaser, Health Insurance Bargaining (New York: Gardner Press and John Wiley, 1978).

9. They remain common in developing countries. An example is the U.S.S.R. All health personnel are full-time salaried employees. But it is tacitly understood that all receive cash payments from patients and their families for adequate services. Since the fees are officially illegal, they are kept to bilateral negotiation between health personnel and patients. William A. Knaus, Inside Russian Medicine (New York: Everest House, 1981), Ch. 15.

10. Glaser, Paying the Hospital in Switzerland.

11. Hirsch S. Ruchlin and Harry M. Rosen, "The Process of Hospital Rate Regulation: The New York Experience," Inquiry, Volume 80 (Spring 1981), pp. 71-72.

12. Glaser, "Controlling Costs through Methods of Paying Doctors: Experiences from Abroad," in Stuart O. Schweitzer (editor), Policies for the Containment of Health Care Costs and Expenditures (Washington: U.S. Government Printing Office, DHEW Publication No. (NIH) 78-184, 1978), pp. 210-213.

13. Glaser, Paying the Hospital in Canada, p. V-27.

14. Convenient lists of the contractual allowances are in Howard J. Berman and Lewis E. Weeks, The Financial Management of Hospitals (Ann Arbor: Health Administration Press, Fourth edition, 1979), pp. 131-132 and 177-179; and Mina Hoover and Robert P. Mullen, "Blue Cross Contract Provisions: July 1, 1979" (Chicago: Division of Financial Management, American Hospital Association, 1979). Detailed rules are in the Medicare Provider Reimbursement Manual (Washington: HCFA, U.S. Department of Health and Human Services, 1978 et seq.) and in the manuals explaining prospective reimbursement, issued by several Blue Cross Plans. The items and the formulae result from a history of wrangles and revisions, described in Herman Somers and Anne Somers, Medicare and the Hospitals

(Washington: The Brookings Institution, 1967), Ch. VIII; and Judith Feder, Medicare: The Politics of Federal Hospital Insurance (Lexington: Lexington Books, 1977), Chs. 4 through 6.

15. Some hospital accountants have devised systems for assigning costs to each class of payer and calculating accurate rates. For example, Woodford W. King, "Budgeting for Contractual Allowances," Hospital Financial Management, Volume 35, Number 1 (January 1981), pp. 58-59. In practice, the calculations are more arbitrary.

16. Manipulations are described in Sylvia A. Law, Blue Cross: What went Wrong? (New Haven: Yale University Press, 1974), pp. 66-93.

17. "HIAA Report on Consumer & Professional Relations: Hospital Relations" (New York: Health Insurance Association of America), #6-81, 26 August 1981.

18. How annual price increases are designed differentially because of the payment rules of third parties is explained in Donald F. Beck, Basic Hospital Financial Management (Rockville, Md.: Aspen Systems Corporation, 1980), pp. 102-111 and 134-139. The basic principles of cost-based pricing are summarized in Berman, op. cit. (footnote 14, *supra*), pp. 203-216. The economic theory behind cross-subsidization to balance the hospital budget is in Jeffrey E. Harris, "Pricing Rules for Hospitals," The Bell Journal of Economics, Volume 10, Number 1 (Spring 1979), pp. 224-243. Evidence that this is done in practice is reported by Fred J. Hellinger, "Hospital Charges and Medicare Reimbursement," Inquiry, Volume XII, Number 4 (December 1975), pp. 313-319.

19. The tortuous negotiations between HCFA and the Washington State Hospital Commission are described in the Second Annual Report of the Commission's Prospective Reimbursement Demonstration Project, October 1978.

20. Comptroller General of the United States, Rising Hospital Costs Can Be Restrained by Regulating Payments and Improving Management (Washington: General Accounting Office, 1980), pp. iv, 21, 42-44, and 65.

21. For example, the many regulations specifying how all French public hospitals must keep their books, fill out the expenditure reports, and fill out the prospective budgets, summarized in André Sonrier,

Comptabilité hospitalière (Paris: Berger-Levrault, Ninth Edition, 1979).

22. Disallowances can be challenged in administrative courts. But once treatment of an item of cost is settled, the hospitals throughout the country adjust. The French case law on disallowances is summarized in Paul Coudurier, Les prix de journée (Paris: Berger-Levrault, Fourth edition, 1978), pp. 58-102 and 112-120.

23. The federal regulations are in Karl Jung and Marianne Preuss, Rechnungs- und Buchführung im Krankenhaus (Stuttgart: Verlag W. Kohlhammer, 1978).

24. Glaser, Paying the Hospital in France, p. VI-8. Paying the Hospital in The Netherlands, pp. VI-34 and VI-35.

25. Glaser, Paying the Hospital in Canada, Ch. VII, *passim*.

26. Les finances du secteur public local: Hôpitaux publics, organismes d'H.L.M. et S.E.M. à participations locales (Paris: Direction de la comptabilité publique, Ministère de l'économie et des finances, 1980), pp. 171-172. During recent years, the franc has varied between \$0.17 and \$0.24.

27. The method is described in general in the Medicare Provider Reimbursement Manual, Ch. 25. Each year's specific methods and index numbers appear in the Federal Register, such as Volume 46, Number 125 (30 June 1981), pp. 33637-33643.

28. Graham Atkinson and Jack Cook, "Regulation: Incentives Rather than Command and Control" (Baltimore: Maryland Health Services Cost Review Commission, prepared for a conference of the American Enterprise Institute, 1980), pp. 9-13.

29. Hoover and Mullen, "Blue Cross Contract Provisions" (op. cit., footnote 14, *supra*).

30. "HIAA Report on Consumer Relations: Hospital Relations" (New York: Health Insurance Association of America, f2-81, 12 February 1981).

31. Travelers Insurance Company v. Blue Cross of Western Pennsylvania, 361 F. Supp. 774 (1972).

32. Carol McCarthy, "Incentive Reimbursement as an Impetus to Cost Containment," Inquiry, Volume XII (December 1975), pp. 320-329;

Katherine G. Bauer, Containing Costs of Health Services through Incentive Reimbursement (Boston: Harvard Center for Community Health and Medical Care, 1973); and Irwin Wolkstein, "Incentive Reimbursement: The Carrot Is There but the Hospitals Won't Bite," Modern Hospital, Volume 119, October 1972. A few American state programs produced a succession of incentive reimbursement schemes, all ineffectual because of their voluntary participation, their small rewards compared to the profits from overspending, and their invisible sanctions. For example, Abt Associates, Case Study of Prospective Reimbursement in Western Pennsylvania (Washington: Health Care Financing Grants and Contracts Reports, 1980).

33. As in the Guaranteed Inpatient Revenue System (GIR) of the Maryland Health Services Cost Review Commission. Also proposed by the Council on Health Care Financing, State of New York, Recommendations for Financing Hospital Inpatient Care (Albany: The Council, 1980).

34. The history of nursing home finance is in Bruce C. Vladeck, Unloving Care (New York: Basic Books, 1980).

35. Catalogued in "Investigating Fraud in Hospitals" and "Hospital Fraud Audit Manual" (Washington: Health Care Financing Grants and Contracts Report, 1980). The exposés are described in United States Senate, Special Committee on Aging, several reports during 1974-1976; and Mary Adelaide Mendelson, Tender Loving Greed (New York: Alfred A. Knopf, 1974).

36. Glaser, Paying the Hospital in The Netherlands, Ch. VI.

37. Glaser, Paying the Hospital in France, Ch. XII, pp. 15-18.

38. Short summary in Glaser, Paying the Hospital in Canada, Ch. VII, pp. 27-30. Long summary in Robin G. Milne, Hospital Budgeting in Ontario (Glasgow: Department of Economics, University of Glasgow, 1977), Chs. 2 through 4.

39. Glaser, Paying the Hospital in Canada, Ch. VII, pp. 18-25.

40. Glaser, Paying the Hospital in England, Chs. IV, V, and VII.

41. R. J. Lavers and Malcolm Rees, "The Distinction Award System in England and Wales," in Problems and Progress in Medical Care: Seventh Series (London: Nuffield Provincial Hospitals Trust and the Oxford University Press, 1972), Ch. 2; and Glaser, Paying the Doctor (footnote 8, *supra*), pp. 215-219.

42. The difficult administration of the productivity bonuses for employees in England is described in Glaser, Paying the Hospital in England, Ch. IX, pp. 7 and 8.

## CHAPTER X

### PAYMENTS BY THE PATIENT

Every society harbors two opposed principles in assigning responsibility for payment of living costs and special services during illness, unemployment and retirement:

1. Self-help. Each individual pays for his own costs and services. If any cannot, he does without them. Ability to pay -- derived from employment, savings, or inheritance -- determines consumption, and therefore levels of provision vary.
2. Social solidarity. Certain services are provided without charge or with sufficient financial help, so that every person can satisfy his needs. Money is pooled by several devices, such as:
  - (a) General taxation, falling particularly on the richer.
  - (b) Social insurance and prepayment funds. Premiums from the prospective beneficiary and from certain other financially strategic groups, such as employers.
  - (c) Charitable organizations (such as churches and voluntary associations) organize the programs, find the money and resources, and provide the services.

For many years, the Anglo-Saxon countries relied primarily on self-help in the financing of health services. They developed many insurance and prepayment schemes to ease the burdens of self-payment at the time of service, programs to help the poor find care, and subsidies for the installations. Payment in self-help societies became a patchwork. Eventually problems in Britain and Canada led governments to wipe the slate clean by simple standardized arrangements financed by them. The patchwork -- still based on a social policy of self-help for most persons -- survives in the United States.

For many years, every European country was a mixture of ideologies and institutions. Principles of social solidarity slowly and unevenly expanded in their institutionalization in every country, constantly criticized and often obstructed by the business, professional,

and agricultural groups that would have to share the costs of others. Side by side in health, institutions based on self-help -- i.e., commercial insurance, private practice, proprietary hospitals -- survived. (The different traditions in health financing are summarized in Chapter III, supra.)

#### COST-SHARING

Issue. Under a self-help system, the patient is supposed to pay all costs out-of-pocket. Indemnity insurance and prepayment for services are consistent with the theory. The United States has evolved a variety of insurance and prepayment channels paid by the patient, as well as his own out-of-pockets. In addition, some social benefits programs exist, whereby needy patients' costs ultimately have been paid by others.

The result in the United States is a confusing mixture of payments by: patients out-of-pocket to the provider; insurance carriers from reserves contributed by patients and/or employers; national and/or state (and local) governments; business organizations; and nonprofit associations. Clinical care of patients by a provider is usually paid for by several different payers who follow different rules. For a particular act, no, some, many, or all patients are expected to pay the provider something, with the rest from a third party.

Difficulties. The payment mixture is the target of many criticisms, depending on the perspective of the speaker. First, the system is unpredictable and hard to understand. It is often impossible to tell a particular person's benefits without a special computer run. Patients with identical clinical conditions and even the same carrier have different benefit packages, requiring different ratios of third-party payments and patient out-of-pockets. At the start of hospitalization, the hospital and the patient quickly establish the patient's coverage by a particular third party. But often they do not know the items of coverage until the bill is calculated upon discharge. Patients often get unexpected charges for items they may not even have known they received. Bills arrive when least anticipated after care has been given

that the patient thought was "free" or fully insured. Bills come from persons whom the patient never expected, such as an anesthesiologist and the emergency room house staff.

Cost-sharing for doctor's fees are even more unpredictable. Individual doctors have their own fees and modify them according to their assessment of the patient's ability to pay, the difficulty of the case, etc. Some doctors consistently accept assignment under some third party programs, some never, others vary from time to time. Usually, American third party coverage is less for physicians' care than for inpatient hospitalization.

Because the cost-sharing rules, premiums, and exclusions are not planned together but are adopted as separate devices to limit costs, certain programs help their beneficiaries much less than intended. For example, only about 40 per cent of the total health care costs of the elderly are paid by Medicare, and only about 26 per cent of their physicians' bills. The elderly spend more of their own money on health care than they did before the enactment of Medicare. Over 15 per cent rely on Medicaid to cover their out-of-pockets.<sup>1</sup>

As I said in Chapter III, supra, political conservatives in the United States argue that cost-sharing by patients is insufficient and not properly targeted. Too few episodes of care require the patient to pay the provider; too few programs charge enough. Too few persons buy their own insurance; often it is paid for entirely by employers. A true health care market can be created only by giving the patient the responsibility of selecting the provider, either at the time of need or in advance with prepayment; it can be created only by giving the patient the incentive to comparison-shop and bargain, so he gets the services he wants at an acceptable price. Then providers will be forced to compete, and prices will be restrained. More consumer choice and consumer responsibility should exist, in insurance as well as in the contacts with providers. Instead of the present widespread over-insurance, persons should have a wider choice of packages, themselves paying for the insurance and then paying the shortfalls when necessary.

Evolution abroad. Paying doctors and hospitals have had opposite histories. Physicians have always been small businessmen ("free

professionals"), charging fees to cover their costs and personal incomes. Patients have until recently always expected to pay in full. European sick funds originated as methods of prepaying: the doctors drew on the financial pool regularly under contracts, or they were paid for each service. Payment of the doctor from a fund receiving little or no contribution by the patient -- e.g., a redistributive pool like the government Treasury -- is recent and still unusual.

In contrast, hospitals originated as charities. Religious associations, private associations, and governments paid for their investments and maintenance. Many employees donated labor. Not until the late nineteenth century, in most countries, were patients charged systematically. Bills at first were not based on costs of care for each case but were forms of additional fund-raising. During the twentieth century, the sick funds to prepay physicians' fees were expanded to cover hospitals' charges. Methods of estimating the cost of each case were developed, so the sick funds would be billed fairly. The goal was to avoid exacting out-of-pockets from the patient, who presumably lost his normal income and had unusual expenses during hospitalization. The hospital was still supposed to be humanitarian -- and still a charity -- that did not drive hard bargains with the sick.

Proprietary hospitals evolved as extensions of the doctor's office, not as part of the charitable hospital sector. Instead of treating the patient at the latter's home, the doctor needed an operating room and beds for surgery. The patients were the wealthier, and all were expected to pay in full. After World War II, private health insurance arose to prepay part of these stays. Laws in some countries were amended to allow the officially insured patients to choose proprietary hospitals, and the sick funds agreed to cover part of the costs.

Self-help methods of payment therefore were used more often for doctors and their private clinics than for nonprofit hospitals. The former were small businessmen in a cash market, catering to self-payers and seeking particularly the more affluent. The self-help methods in health payment were eventually eclipsed by more collectivist methods everywhere, first in the Germanic countries and later in the franco-phones.

Current methods abroad. Cost-sharing of some sort exists in every country today, even those with universal coverage and Treasury financing. Always (except in Italy and Japan), copayments\* are required for drugs and prostheses, items that might be ordered and wasted if paid for exclusively by sick funds or by government. Cost-sharing is usually required for ambulatory care by providers, such as physicians, dentists, and physiotherapists. Few countries have any cost-sharing for inpatient hospital care, since hospitals are still assumed to give "free" care to the helpless. In countries requiring cost-sharing for hospital care, many patients are exempt. Cost-sharing exists for proprietary hospitals, since in most countries they are considered extensions of doctors' private practices.

Every hospital system in developed countries offers extra services, such as private rooms, room telephone, room television sets, and so on. The package varies by countries but usually includes the one-bedded and two-bedded rooms. The patient choosing them is expected to pay. Private health insurance carriers sell policies prepaying these special charges.

Motives and evolution of cost-sharing abroad. Where cost-sharing exists abroad no single "reason" exists. It has usually evolved over long periods, and the motives of earlier actors differ from the recent ones'. Like all big political decisions, its adoption (and subsequent redesign) result from an interaction among many actors, each with different motives; so, no single "reason" for enactment exists. Some predominant themes occur, either during the origin or the stabilization of cost-sharing, viz., a by-product of a cash benefits method; the need for revenue by the sick funds; limitation of coverage.

(1) Cost-sharing becomes a national custom, as a by-product of a cash benefits method of insurance. This method developed in countries with a self-help style of financing physicians' care, such as France,

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\*A "copayment" is a flat sum for each service, such as \$1 for each prescription or \$1 for each visit to a physician. "Coinsurance" is a proportion of costs, such as billing the patient himself for 10 per cent of every bill from a physician. A "deductible" is a maximum sum that must be paid by the patient for all his bills -- such as \$60 for all health costs -- and thereafter the sick fund or government pays the providers.

Belgium, the United States, a few parts of Switzerland, and (formerly) certain office doctors in Sweden. In these cases, the medical profession was fiercely independent, insisted on a direct payment by the patient, and refused to deal directly with insurance carriers. Therefore, the sick funds had to agree to reimburse the patient after the latter paid the doctor's bill. The doctors reserved complete freedom to fix their own fees, but insurance carriers could not agree to pay without limit. So, the sick funds set a reimbursement schedule; in France, the sick funds agreed to pay slightly less than the fees in the reimbursement schedule, so that the patient would have to contribute something, even in the unlikely event he found a doctor who would charge no more than the schedule.

The method has been coinsurance: the sick fund reimburses the patient a percentage of the fee in the reimbursement schedule. In France, the proportion has usually been 20 per cent or 25 per cent.

Original motives were mixed. The medical associations were trying to preserve under NHI the traditional freedom of each doctor to set his own income. The French medical profession added a sociological reason: close personal relations (entente directe) were said to be essential in patient-doctor relations, and transfer of cash was part of the cement. Sick funds seemed willing to accept cost-sharing at first, in the hope that patients would avoid the more expensive doctors and their private clinics.

Countries with such arrangements eventually take them for granted and usually adopt them for hospitalization, without any fundamental debate. Even though nonprofit hospitals do not share the doctors' fierce independence, do not charge patients by sliding scales, and even prefer collectivist methods as a guarantee of recovering their costs, patients' cost-sharing rules are applied to them. For example, France has adopted for inpatient hospitalization its usual method: coinsurance of 20 per cent of the full bill or (for serious illnesses) 20 per cent of the nonclinical costs.<sup>2</sup>

Evolution may eliminate the original circumstances but not the coinsurance itself. For example, doctors and hospitals eventually accept direct payment from sick funds and send second bills to the patients, to

collect their contributions, as in France. The French doctors have been forced by government to accept the reimbursement schedule as payment in full, and they must collect fixed amounts from two sources. French hospitals have been under the prefects' price controls for a century, and they too must bill two payers.

France has fixed rates and standard coinsurance percentages, but not the United States. Some American hospitals have agreed to payment in full by state Blue Cross Plans; some doctors agree to payment in full by state Blue Shield UCR Plans or under national Medicare CPR, but others refuse. A doctor can switch from paid-in-full Medicare assignment to non-assignment with heavy patient cost-sharing from one bill to the next, even for the same patient. Some doctors separately bill carriers and patients, as in France; some still collect in full from patients and let the patients bill the carriers; some accept Medicare assignment one time and refuse the next for the same patient. American patients' out-of-pockets are not fixed, as in France, since doctors in these situations do not follow the carriers' reimbursement schedules, and because two carriers (even including state Blue Shield Plans) do not have the same schedules.

(2) Cost-sharing becomes a source of revenue for the carriers. Britain's National Health Service began as a paid-in-full public service in all respects, like the governmental elementary and high schools. When costs rose faster than expected during the late 1940's, the Treasury insisted on either cuts in service or charges. Since hospitals were the principal drain, Treasury recommended a copayment of 10 shillings per inpatient week. The compromise between the Ministry of Health and the Treasury in 1950 was copayments falling not on clinical care, but on supplies, such as drugs, certain dentures, spectacles, prostheses, wigs, etc. The charges would fall only on those better able to bear them, viz., the ambulatory patients and not the inpatients. Hospitals would become involved only when giving supplies to outpatients.

A Labour Government during the 1960's repealed the charges but soon had to choose among restoring them, cutting services, or increasing general taxation. The least difficult action was to restore the charges that had nearly become customery. They have remained ever since and have

become indispensable to the NHS budget, bringing 2.2 per cent of its income during 1978. Charges have steadily increased and are now indexed to inflation: although other NHS services are cheaper than foreign equivalents, since all are free, the charge per item on a prescription is now £1 (about \$1.90 in early 1982), nearly the highest of any organized third-party payment system in the world. The charges apply to all hospital patients after discharge and to all ambulatory patients. Since the motive is to raise revenue and not regulate the behavior of patients and providers, and since charges are sought by Treasury and opposed by DHSS, announcement of the charges is often made by the Chancellor of the Exchequer in the annual Budget Message, and not by the Secretary of State for Social Services.<sup>3</sup>

Sick funds in Switzerland have precarious finances, since employers contribute no health insurance taxes. In countries with stronger traditions of social solidarity, employers contribute and health insurance becomes compulsory and nearly universal. But Switzerland has retained traditions of individual self-help longer than most European countries. The sick funds depend primarily on subscribers' premiums, and the person can choose among benefit packages with varying premiums. One method of matching costs to revenue is avoiding unpredictable numbers of dependents: every person covered (i.e., spouse and each child) must buy his own policy. The national government helps the sick funds by direct cash grants but sometimes limits the grants because of its own budgetary problems, as in the cutbacks of 1975. Swiss sick funds pay providers in full but then require patients to repay some costs, the only such method in the world. (Normally cost-sharing requires the patient to pay the provider.) The patient is billed 10 per cent of the cost of all ambulatory care, with a certain minimum (the Swiss version of a deductible) every quarter. The deductible varies by the patient's income.<sup>4</sup>

Advocates of cost-sharing forget that it involves collection costs which reduce gains from revenue and which may burden the system as much as it deters the user. The Swiss method of retrospective billing reduces collection costs but, since cash payment is not at the point of service, attenuates deterrent effects. An advantage of third party

payment is the saving in administration, but it is lost when the hospital must send a separate bill to every patient for his cost-sharing, as in France.

(3) Exclusions. In countries with a strong self-help tradition, payment of hospital services by third parties never becomes complete. Originally, the norm was personal cash payments for everything by the patient. Gradually indemnity insurance, prepayment, and special welfare programs cover essential care. Some clinical care and many less urgent services are never included in the basic package, but the patient can buy an extra voluntary insurance policy to cover them. Some persons pay these items out-of-pocket. This sort of uneven coverage for hospital care is very common in the health insurance system of the main surviving example of self-help financing, the United States. Even programs that are thought unusually generous -- such as Medicare -- have many exclusions, to the surprise of beneficiaries.

Exclusions exist in foreign systems, but they are standard for all carriers, and the patient is forewarned. Unusual in its magnitude, an example exists in Switzerland. The national government's subsidies to the sick funds are designed to cover clinical costs. The cantonal governments' subsidies to the hospitals are designed to help pay the balance of the clinical costs and not the patients' amenities. The basic health insurance system therefore is designed for clinical care, and all hospitals calculate clinical costs separately from the food, living costs, and extra comforts afforded patients. The cantonal government contributes to the clinical costs from its general revenue, the sick fund pays the rest (the Spitaltax), and the patient subscribes to an insurance policy contributing his share. The patient is expected to pay the hotel costs in full (the Pensionszuschlag; usually he covers that canton's rates by buying a supplementary insurance policy from his carrier. A few patients pay the Pensionszuschlag out-of-pocket.<sup>5</sup>

Expensive extra amenities are excluded from a country's standard definition of basic hospital costs and are not included in the basic health insurance policies. Examples are the extra charges for private rooms of one or two beds. Patients are expected to pay the surcharge personally. In Germany, where every other element in hospital costs is

included in the negotiations between sick funds and hospitals, the funds consider the private room charges a direct personal transaction between hospital and subscriber, the hospital can charge what it likes, and the hospital keeps the income without reporting it as offset revenue in the Selbstkostenblätter.

Splitting the basic care into elements, and leaving some for the patient's own responsibility, as in Switzerland, is very unusual. Almost everywhere, clinical care and housing are in the basic insurance policy or in the global budget paid by the Treasury. Even the extra amenities are often covered in supplementary policies, so the patient's cost-sharing really is his supplementary premium to the carrier, not a point-of-service payment to the hospital.

(4) Cost-sharing to recover windfall profits. Most countries arrange to recapture money from welfare programs that would pay a patient twice. For example, the elderly and the permanently disabled receive pensions. Hospitalization insurance usually covers extended care or hospice care. The patient is often expected to pay some of his pension for his living costs in the nursing home, lest he be paid twice and leave the surplus to his heirs.

Effects of cost-sharing abroad. American advocates of patient cost-sharing think it will: (a) deter unnecessary utilization and waste; and (b) make patients more cost-conscious, lead them to comparison-shop, and lead them to bargain with providers. The two motives are distinct.

If cost-sharing were very large, as some Americans suggest -- i.e., very high deductibles, premiums paid entirely by patients -- it would certainly deter use. The entire health service system would be oriented toward those able to pay. Many persons could obtain nothing but charity, and the conservatives who oppose generous health insurance also oppose the public expenditure for welfare. Cost would be restrained: hospitals and doctors would work on shoestrings. But national health insurance and national health services were designed to expand access and pump more resources into health services.

The real question is whether the levels of cost-sharing found under modern national health insurance deter use. European experience

suggests that the effects on utilization of doctors and hospitals are small. Coinsurance and copayments are low, the general public has become affluent enough, and the public gets accustomed to the payments. Persons who might be affected by large payments -- the very sick, the elderly, and the poor -- are exempt on humanitarian grounds. If cost-sharing is suddenly increased, utilization may be limited temporarily, but the long-term effect is negligible.\* A close examination of the American and Canadian research also shows limited permanent effect on utilization, even though some of the original authors struggled to prove otherwise.<sup>8</sup>

Cost-sharing may have the reverse effect of attracting customers to certain more expensive providers, although no research has addressed this hypothesis. Medical care is a field where customers want the "best," and the most expensive may be interpreted as the "best," while cheap or free services and products may be thought ineffective. When Belgian national health insurance adopted variable copayments for drugs to deter purchase of proprietaries and motivate acceptance of generics, the result was the opposite: patients opted for the more expensive proprietary drugs with the higher copayments.<sup>9</sup>

Cost-sharing is never enforced as strictly abroad as theorists would like. National health insurance is supposed to help the unfortunate, not threaten them with poverty unless they drive hard bargains with hospitals and doctors. Therefore French sick funds pay in full all hospital and doctors' fees for patients with financial hardships, disability pensions, one of the twenty-five most serious illnesses, or over thirty days of hospitalization. So many persons plead hardship in Great Britain that only about 40 per cent of the prescription charges are collected.

If one is an advocate of a "free market," one cannot really argue with the fact that carriers jump in and sell policies to cover the cost-sharing. The carriers are private and defy any attempt by a

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\*A sudden and temporary increase in coinsurance in radiology in France in 1959 seemed to have little effect on the long-term trend in utilization.<sup>6</sup> After Saskatchewan introduced a copayment of \$2.50 for each day in the hospital in 1968, utilization briefly diminished, particularly among the poor, but thereafter it continued to rise as before.<sup>7</sup>

dogmatic conservative government to require the patient to pay the cost-sharing personally. When the French government several times forbade the sociétés mutualistes to insure for the cost-sharing, the disputes contributed to the successful general strike of the working class that almost overthrew De Gaulle in 1968 and contributed to the electoral victory of the Socialists in 1981. While increases in cost-sharing have uncertain economic effects, they have clear political effects. The opposition party uses it as ammunition in the next election, and governments that have tried to raise cost-sharing have repeatedly been defeated or severely weakened at the next election: Great Britain in 1951 and 1970; France in 1981; Germany in 1961 and 1965; Saskatchewan in 1971. The new incumbents -- if Leftist -- in later elections warn voters that restoration of the old regime will bring back cost-sharing. In public opinion polls, most persons prefer paid-in-full health insurance with higher premiums to less inclusive coverage with lower premiums.\* Politicians have concluded that cost-sharing is a dangerous policy, best never mentioned. Therefore, all the literature arguing for cost-sharing and modelling its beneficial effects is relevant only where paid-in-full hospital care is not yet in effect and where policy options still exist -- i.e., in the United States but in few other developed countries.

#### SOCIAL INEQUALITIES AND PRIVATE PRACTICE

In every society, health correlates with social and economic class. As long as personal payment is required for access to health services in whole or in large part, utilization correlates with class, and facilities and health personnel will cluster where the money is. During the nineteenth and early twentieth centuries, financing of hospital care was a mixture of different sources but relied somewhat on personal out-of-pockets in every country. Churches, local government and

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\*Since the Dutch private insurance companies sell policies with cost-sharing and must work in a free-spending system, they have often recommended generalizing cost-sharing as a restraint on Holland's cost explosion. In a national survey in 1966, 52 per cent of the Dutch population preferred full NHI coverage with high premiums over policies with cost-sharing and lower premiums.<sup>10</sup>

voluntary associations operated hospitals, they exempted many patients from charges, and the poor were not completely debarred. The richer a person in all countries, the greater his choice of hospitals and of doctors, and the better the quality and comforts.

The great innovations in health care financing were designed to weaken the correlation between personal income and access. Like the Church and charitable associations before, sick funds and governments assumed the humanitarian mission of guaranteeing universal access to adequate services when people of any class needed them, regardless of ability to pay. Facilities and health personnel were redistributed closer to the lower classes. Countries retaining a self-help ideology -- notably Great Britain and Canada -- eventually abandoned it in health and guaranteed universal access through large government expenditures.

Previously a dichotomy existed between those who could pay and those who could not in all foreign countries: the payers varied in ability to purchase health services as in all other services; others received care for "free." As national health insurance grew, a trichotomy developed: the insured covered by sick funds; the poor who still got free care; and the self-paying rich who relied on "private practice." Because health services take on the class identity of their customers, they became trichotomized during much of the twentieth century in countries with NHI: the facilities for the poor, for the insured, and for the rich.

The American situation. As I said in earlier chapters, the United States has retained its self-help philosophy of health payment and has shored it up with a melange of devices. Some financial methods are designed to help the patients, others to guarantee cost reimbursement for the hospitals. Patients' out-of-pockets are scattered throughout. Class differences have never been eliminated within the society; the presence of unassimilated racial and cultural minorities in a competitive social order results in greater inequalities of power and living standards than in any other developed country. Since the United States has never enacted general Treasury financing of all health services for everyone and has never enacted national health insurance, access to health services and the location and character of facilities remain

related to the class structure. The differences among classes and races in health status and in character of available facilities appear to the traveller the widest of any developed country.<sup>11</sup> The large number of low income persons with neither Medicaid nor comprehensive health insurance and the fiction that they must and can buy their own health care saddles the American hospital with a large number of bad debts and a charity load, both long gone from hospital finance in every other developed country.

Evolution abroad. The problem abroad has been to level upward, to enable the lower and middle classes to obtain through insurance and subsidies the health services that the richer could buy. National health insurance was the mechanism -- at first voluntary, uneven in coverage, limited in resources; later compulsory, with steadily wider coverage of the population, with steadily larger benefits, and better financed. Until recently, membership was based on employment; more categories of the employed and self-employed were added to the basic coverage. Recently, several countries have added the unemployed and retired to membership in the basic sick funds, with the help of Treasury subsidies.

Levelling upward was simple and instantaneous whenever a National Health Service or universal Treasury financing were adopted. (The former in Britain, the latter in Canada.)

Current methods abroad. Levelling has been upward and never downward. Private medicine for the richer has never been restricted by law in Europe or North America. Any person may see a doctor privately and pay cash, as in the past. Private hospitals can still exist.\* If nonprofit and public hospitals had private services, usually they survived. The charges were only to provide the population with the means to receive care without out-of-pockets or with the minimum cost-sharing described earlier in this chapter.

One-third of the trichotomy -- i.e., charity for the poor -- has disappeared. But the distinction remains between insurance practice

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\*Perhaps the only exception in a non-Socialist country is The Netherlands. When its religious traditions were still strong, it enacted a licensing law defining a hospital as non profit.

and "private practice." (Or, in countries with NHS, the distinction remains between "health service" practice and "private practice.") Americans do not employ the verbal distinction, since they think of all health care as "private practice," with the providers collecting from third parties and from the patients themselves.

The distinction between insurance practice and private practice abroad is eroding, because so many persons now are satisfied to use sick fund coverage and mainstream hospitals. "Private" medicine no longer implies out-of-pockets but now usually is covered by third parties, viz., by voluntary purchase of commercial insurance or by voluntary purchase of supplementary policies of the sick funds, depending on the insurance practices of each country.

Private payments are made for the following:<sup>12</sup>

1. Inpatient care in proprietary hospitals. Not all of it, since many patients have basic sick fund coverage, and some proprietaries have negotiated per diem charges with the sick funds. To be described in the next chapter.
2. A very few items in nonprofit and public hospitals. Mentioned earlier in this chapter:
  - (a) Private and semi-private rooms.
  - (b) Special amenities, such as telephone and television.
  - (c) In a few countries, charges for outpatient services, if the patient is seeing the hospital doctor privately.
3. Inpatient care by senior physicians, if there is an explicit agreement between doctor and patient:
  - (a) Usually, but not always, care in proprietary hospitals. In some countries, the hospital doctors are authorized to collect fees from the sick funds under the negotiated fee schedules for care in the proprietary hospitals, as if they were the doctors' private offices.
  - (b) A few patients in the nonprofit and public hospitals pay the chief of service privately, to be sure that he rather than the house staff treats them. Scope for this private payment within hospitals otherwise financed entirely by sick funds and governments varies among countries. Usually these patients are in the

private rooms; usually, but not always, the private room patients retain the chiefs privately.

4. Ambulatory care, if not paid by sick funds or by a national health service:

- (a) Outpatient visits to senior staff physicians in the nonprofit and public hospitals. Usually these are covered by NHI or by an NHS, but exceptions exist. In Germany, only a few hospital doctors (the Belegärzte) are eligible to bill under NHI, whose medical fees are restricted to office doctors; therefore, a hospital doctor can be seen on an ambulatory basis only privately.
- (b) Office visits to specialists.
- (c) Office visits to general practitioners. Private general practice care has disappeared almost completely, and patients use their NHI or NHS coverage to see GP's.
- (d) Office visits to dentists. Coverage under NHI and NHS is incomplete, so much dentistry is still performed privately. Amount varies among countries.

Once a substantial number of the self-employed and the civil servants were not covered by NHI and therefore had to see doctors and use hospitals privately. Even the middle classes after coverage by NHI often thought it safer and more comfortable to retain the doctor privately and to go to a private clinic, particularly for surgery and obstetrics. But now nearly everyone is covered, and the nonprofit and public hospitals have become more modern and more comfortable. Patients now opt for private care because they want personal attention from a particular doctor and because they want a still more comfortable setting than the ordinary hospital.

A few citizens remain, not covered by the official programs. They must use private health insurance and private practice. The only Western country where the number remains large is The Netherlands, where obligatory or voluntary health insurance applies only to persons earning up to a particular limit, viz., about f. 40,000 during the early 1980's. The remaining 30 per cent of the population must either self-pay or buy private health insurance, and nearly all obtain policies from commercial

carriers. The doctors define them as private patients, liable for higher fees than in the official negotiated schedule.<sup>13</sup> The hospitals cannot charge them higher rates, but they are more profitable than the ordinary patients, since their policies enable them to use private rooms.

Another significant group of private patients is foreign businessmen and their families. Most are covered by executive benefits plans of their companies. They are important sources of private health expenditure in the great international cities, such as London and Paris.

As always in the past, the principal interest in private medicine has come from the physicians, particularly the specialists. For almost all, steadily larger proportions of their incomes are paid by controlled official sources, such as the fees of sick funds and the salaries of hospitals. They welcome cash from private practice, since it is extra, partially concealable from tax collectors, and a symbol of vanishing professional freedom. A few notable hospital chiefs of service can earn much extra money; they may keep some, use some to support research work in their services, use some to hire extra assistants and secretaries. A few office doctors have strong professional credentials and connections to flourish in a predominantly private practice, but they are unusual.

Private medical practice is essential to the operation of the proprietary hospitals. The physicians on the staffs use the establishments in lieu of private offices and steer their patients into the in-patient beds. Since the proprietaries cannot collect profits as allowable costs in the daily charges, and since they must keep their charges low to attract patients away from the nonprofit and public hospitals, they can survive only by recapturing practice costs from their physicians' fees.

The nonprofit and public hospitals gain some revenue from the private room charges. Usually it is counted as offset revenue, and the sick funds (in NHI countries) and Treasury (in NHS countries) do not have to pay out so much. Therefore, the third parties benefit more than the hospitals themselves. If they didn't, they would oppose all private practice in the nonprofit and public hospitals. They tolerate private practice to appease the doctors and to avoid having to pay for all care.

Private practice is not supposed to operate to the detriment of the official NHI or NHS schemes. Always double-billing is banned: if the doctor collects cash from the patient, he cannot bill the sick fund too. Once the hospital doctor spent much of his day in the private clinic where he earned most of his income from private practice; but, in return for the very high salaries from the hospital, ultimately paid by the sick funds or government, he is expected to spend all his time in the hospital and devote nearly full attention to the patients covered by the official schemes. In return for private fees, the doctors are not supposed to give better clinical care than to the patients covered by the official schemes, only more personal attention.

The sick funds cannot pay whatever hospitals and doctors ask, and neither can the commercial insurance companies that cover private practice. They join the sick funds in a common front when setting the daily rates for the private rooms of the nonprofit and public hospitals and the daily rates of proprietary hospitals. Both the sick funds and the commercial insurers occupy the seats for payers in Holland's COZ. While the private insurers usually do not sit with the official sick funds in Germany when bargaining with the individual hospitals (whether nonprofit, public, and proprietary), their less inclusive daily charge is based on the all-inclusive one negotiated by the official funds, viz., the full-charge minus physicians' costs, since they pay the medical fees separately. When paying doctors, the commercial insurers either agree on their own fee schedule with the medical association (as in Holland) or limit their liability by reimbursing the patients according to an indemnity schedule. If the individual wants to pay the doctor more, he can out-of-pocket. Only the exceptional fancy hospitals catering to the very wealthy and to foreign businessmen charge very high rates.

#### LESSONS FOR THE UNITED STATES

Cost-sharing. It is misleading to speak of cost-sharing-in-general. The question is what forms of payment by what classes of persons for what types of care. Drugs and prostheses may often be wasted,

copayments may deter wasteful acquisition, and they may deter some utilization as well. Point-of-service payment may deter some ambulatory visits to the doctor, by the poor and by the "worried well" of all classes. Large cost-sharing for hospitalization may deter some in-patient admissions, but one cannot tell, since usually persons most likely to be affected are exempt. The most expensive component of health care costs -- inpatient hospitalization -- is the element least affected by cost-sharing.

The trend is toward more paid-in-full hospital payment by third parties. Restoration of cost-sharing for basic hospital care -- or, for anything else, once abandoned -- is very unusual. Cost-sharing is more common for physicians' services.

Extra services are excluded from the definition of basic hospital services and in theory are subject to full payment by the patient. However, most buy supplementary insurance to cover them in full.

Charges for patients for basic services are usually small. If patients actually pay out-of-pocket (instead of relying on supplementary insurance), the amounts are too small to deter utilization. They become routine for all citizens.

If a patient is seriously ill or is hospitalized for a long time, any cost-sharing is waived. Therefore, it has no effect on large expenditures.

The poor are usually exempt from cost-sharing, either under the main benefits program or under welfare supplements.

Therefore, the very large cost-sharing that would have a substantial impact on utilization never arises abroad. Hospital care has always been a humanitarian service and still is. Actually, the possibility of finding in the United States a hospital and leaving unpaid bills makes a mockery of cost-sharing as a policy for hospital payment here, and it always will.

Cost-sharing rules in every country except the United States are simple and comprehensible to the patient in advance. A "rational" response to cost-sharing is impossible if the patient cannot anticipate his liability.

Revenue gains from cost-sharing are offset by some collection costs. The administrative advantages of third-party payment are nullified by the need to collect money from each patient. Simple collection methods, like retrospective periodic billing by the sick fund, may increase net administrative savings but may weaken the deterrence upon utilization.

Belief in cost-sharing is an outgrowth of ideology, whether one believes in self-help or social solidarity as a principle of personal security, whether one adheres to the political Right or to the political Left. But prevailing social ideologies are not implemented exactly, since the persons who will pay find methods to avoid it. While a country's health payment system may have institutionalized cost-sharing, in practice the public finds ways to avoid it, as in France. In a free market, the insurance industry sells protection against cost-sharing, like any risk.

Private practice. As national health insurance expands, private practice diminishes, in both the hospital and office sectors. If a national health service is enacted in a developed country, it disappears very quickly. When the nonprofit and public hospitals are modernized and the medical staff becomes full-time, fewer people want private hospital care, either in proprietary hospitals or in special private services of the others.

Private medicine brings few benefits to the nonprofit and public hospitals under NHI or NHS. The chief beneficiaries are the doctors, but their opportunities for outside uncontrolled fees diminish. The third parties -- sick funds and Treasuries -- are somewhat relieved by transfer of part of their burden to the private market.

Private medicine becomes assimilated into the insurance system. Few patients pay a great deal out-of-pocket. Often the hospitals (whether nonprofit, public, or proprietary) charge private patients by a prospective schedule closely related to the sick fund charges. Even many of the doctors follow a fee schedule in private practice.

## FOOTNOTES

1. Subcommittee on Health of the Committee on Ways and Means, U.S. House of Representatives, Physician Reimbursement under Medicare: Current Policy, Trends, and Issues (Washington: U.S. Government Printing Office, 1980), pp. 3-4; Karen Davis and Cathy Schoen, Health and the War on Poverty (Washington: The Brookings Institution, 1978), Ch. 4; and Charles R. Link et al., "Cost Sharing, Supplementary Insurance, and Health Services Utilization among the Medicare Elderly," Health Care Financing Review, Volume 2, Number 2 (Fall 1980), pp. 25-31.

2. Glaser, Paying the Hospital in France, Ch. II, pp. 8-11; and Ch. XI, pp. 2-3.

3. Glaser, Paying the Hospital in England, Ch. VIII, pp. 6-7.

4. Glaser, "Controlling Costs through Methods of Paying Doctors: Experiences from Abroad," in Stuart O. Schweitzer (editor), Policies for the Containment of Health Care Costs and Expenditures (Washington: National Institutes of Health, U.S. Department of Health, Education and Welfare, DHEW Publication No. (NIH) 78-184, 1978), p. 232.

5. Glaser, Paying the Hospital in Switzerland, *passim*.

6. Simone Sandier, "L'influences des facteurs économiques sur la consommation médicale," Consommation, Volume 13, Number 2 (April-June 1966), pp. 85-87.

7. R. Glen Beck and John M. Horne, An Analytical Overview of the Saskatchewan Copayment Experiment in the Hospital and Ambulatory Care Settings (Toronto: Ontario Council of Health, 1978); and John M. Horne, Copayment and Utilization of Publicly Insured Hospital Services in Saskatchewan: An Empirical Analysis (Ottawa: dissertation for the Ph.D. in economics, Carleton University, 1978).

8. See the thorough and penetrating reanalysis of the American and Canadian literature in Morris L. Barer, Robert G. Evans, and G. L. Stoddart, Controlling Health Care Costs by Direct Charges to Patients: Snare or Delusion? (Toronto: Ontario Economic Council, 1979). The facts and evidence about cost-sharing in Canada and several other countries are summarized in Robin Badgley and R. David Smith, User Charges

for Health Services (Toronto: Ontario Council of Health, 1979). The principal American research project about the effects of cost-sharing reports that greater cash requirements are associated statistically with fewer ambulatory visits to doctors, slightly fewer hospital admissions by adults, no reductions in hospital admissions by children, and no reductions in cost per inpatient stay. Joseph P. Newhouse et al., "Some Interim Results from a Controlled Trial of Cost-Sharing in Health Insurance," The New England Journal of Medicine, Volume 305, Number 25 (17 December 1981), pp. 1501-1507. Some of the experimental cost-sharing requirements far exceeded what any government and the prepayment-insurance system are likely to require.

9. Theodore E. Chester, "The Effects of Copayments and Charges on the Utilization of Health Care" (Manchester: Department of Social Administration, University of Manchester, 1973), p. 26.

10. An example of the private companies' proposals is Advies: Inzake de structuur van de verzekeringen tegen kosten van geneeskundige verzorging (The Hague: Uitgave van de Sociaal-Economische Raad, Number 19, 16 November 1973), page III-17. The question was asked by Attwood Statistics (now called Interact), Enquête 66.06.77, August 1966, Question 16.

11. Described in David A. Kindig et al., "National Health Insurance for Inner City Underserved Areas," in William R. Roy (editor), Effects of the Payment Mechanism on the Health Care Delivery System (Washington: National Center for Health Services Research, 1978), pp. 60-67 and sources cited.

12. These paragraphs synthesize details appearing in scattered places throughout my several monographs about payment of hospitals in individual countries.

13. The bulk of the negotiations take place between the price control office of the Dutch national government and the national medical association. Glaser, Health Insurance Bargaining (New York: Gardner Press and John Wiley, 1978), pp. 90-91.

## CHAPTER XI

### SPECIAL TYPES OF HOSPITALS

#### PROPRIETARY HOSPITALS

United States. During the recent wave of policy recommendations about introducing "national market competition" into health, the proprietaries have become role models. Several health economists propose incentive reimbursement schemes and other forms of efficient and accumulating behavior that best fits the proprietaries. The professional association of the proprietary hospitals led the political lobbying that killed the Carter Administration's cost containment bill, since it would have hurt them the worst. High officials of the Reagan Administration recommend that the nonprofit and public hospitals learn to operate like the proprietaries.\* Recruiters for graduate programs in hospital administration point to creators of multihospital proprietary chains, as proof that the career can yield millions of dollars.<sup>2</sup>

But are the proprietaries really a firm and influential element in the American hospital structure? Is the recent attention over them a form of ballyhoo that frequently surrounds a new theme in American life and quickly fades? Do their survival and growth depend on conditions that are permanent or fleeting?

Over the long view, private for-profits have diminished in number and in market share, in the United States as in other countries, although they have recently revived in new forms. In America, as in Europe, they began as individual doctors' private clinics, with a few beds apiece, really extensions of the doctors' private offices. Previously the poor were taken to the hospital while the middle and upper

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\*Asked "How does a Government that is opposed to controls get control over a multiplicity of health costs in the private sector?", the Secretary of the Treasury answered: "By insisting upon efficiency and productivity to equal the amount of price increase. . . . It has constantly amazed me that there are private hospital companies in the United States that operate very profitably and their costs are not any higher or not as high as the many Government-owned facilities."<sup>1</sup>

classes were treated by their personal physicians in their own homes. Clinical progress meant that the doctor could accomplish more with his patients than was possible in the patient's home, but paying patients did not want to enter the hospitals, since it had large wards for the poor and his private physician might not have had attending privileges. The solution was the "private clinic" for treatment and convalescence of (particularly) surgical and obstetrical patients. The private clinic by itself was not "for profit." It was part of the doctor's entire accounts, and he earned income in addition to his costs. He was a "for profit" self-employed businessman. Until modern income taxation and modern rate regulation, doctors never had to keep separate books for their private clinics.

Many private clinics were created in areas where voluntary and public hospitals were scarce. In 1910, about 56 per cent of all American hospitals (i.e., about 2,441) were private clinics. But they steadily declined in number until the early 1970's. More voluntary and public hospitals were built, the old ones became modernized, and the middle and upper classes used them. Doctors could use the voluntary hospitals as if they were private workshops and no longer needed the bother of running private clinics. Quality and safety regulations by JCAH and state governments made clinic ownership less profitable, while insurance made unfettered professional practice as a physician alone more profitable. Many private clinics were absorbed into the new nonprofit and public hospitals. The survivors looked different from the simple private clinics of the past: many were owned by partnerships of several doctors, rather than by one; some were owned by lay businessmen; many were incorporated rather than being merely the workplace of one doctor. By 1968, the number of for-profit private hospitals had diminished to 769, constituting 11 per cent of all hospitals and 5.8 per cent of all beds,<sup>3</sup> but the composition was evolving from the old "private clinic" to the modern "proprietary hospital."

The private for-profits have always been more volatile than the nonprofits and publics. With fewer assets per bed and more adaptable buildings, they sell out and are started up at higher rates than the others. During the 1970's, for the first time, new entrants exceeded

closings. Recent innovations in financing and management -- incorporation, lay ownership, chains, capital accumulation from sales of stock -- became common. As I reported in Table II-1, supra, by 1977, the proprietaries had increased to 975 (including the nonregistered), 13.5 per cent of all hospitals, but the proportion of all beds had declined to less than 4 per cent. As before, most have fewer than 100 beds.

Like every business, the proprietaries depend on favorable market opportunities: no strict rate regulation; low market share by stingy cost reimbursers; few established competitors. For many decades, they have concentrated on the parts of the country where population growth has exceeded the construction of voluntary hospitals (i.e., the Sunbelt and Far West), and they have continued to disappear in the Northeast and Middle West. For several decades, two-thirds of all proprietaries have been in the West South Central and Pacific census regions.<sup>4</sup>

Much euphoric publicity has recently surrounded the proprietaries, because chains have been created, they have become involved in some of the takeover struggles that excite the financial publications, and they have expanded abroad. They encourage the publicity, since they can attract new capital and management contracts. But actually they are creating only a few new facilities. In 1981, American investors were building 13 completely new hospitals within the United States, they were building 11 completely new ones abroad, and they were expanding 63 existing American ones.<sup>5</sup> While the companies are creating new hospitals at a cautious pace, some are expanding far more quickly in what might become more profitable and more secure work, viz., management services for nonprofit and public hospitals within the United States.

For-profit proprietary hospitals of the American type have survived and occasionally prospered because of particular features of the American structure of health services and health finance:

1. Like any business, it can reject certain classes of customers on grounds their third parties don't accept the price schedule (Medicaid and, often, Medicare), they have no money (charity cases and potential bad debts), and the proprietary is not set up for their

needs (the chronically ill). Enough nonprofit and public hospitals exist nearby so that the proprietary is neither legally nor morally obligated to accept unprofitable patients.

2. Like any business, it retains energetic salesmen. The attending staff system creates a large pool of captive customers. In the larger investor-owned proprietaries, an attending is replaced if he brings in too little business.
3. No single third party has predominant market share, particularly not a cost-reimburser. Since health service organization is a state-level activity in the United States, Blue Cross is weak in many parts of the country in its market power and rate-setting methods. Cost reimbursers should be avoided and charge-payers favored, since the proprietary needs to accumulate money to pay off capital loans and save for new investment.
4. All or nearly all third parties and self-payers pay the proprietary's charges. The proprietary fixes the charges with a minimum of negotiation.
5. Little or no governmental rate regulation. The American federal system installs separate regulatory arrangements in different states, and many states have weak or no restraints.
5. Permissive governmental and professional standards of personnel. Decided federally in the United States, the lower the standards, the more profitable the hospital.
7. Cost-reimburser are willing to pay a "return on equity."

Europe and Canada. As in the United States, private clinics have steadily declined in numbers abroad, because of the difficulties of fitting them into hospital plans, the payment rules of national health insurance, and stricter quality standards.

Several countries have hospital plans written by Ministries of Health with the aid of consultative commissions. Capital grants are given to expand or modernize facilities that serve the plan. Usually all public and nonprofit hospitals are included almost automatically. The proprietaries are usually ignored; some are included in a few countries (particularly France and Germany if they fill gaps left by the public and nonprofit institutions). Even if they are included in the

plan, the for-profits may have difficulty getting grants or loans from investment funds, since the nonprofits and publics enjoy priority and the taxpayer's money is not supposed to be used by profit-makers.

A proprietary abroad cannot collect a profit from sick funds. Laws and regulations obligate the carriers to cover the hospital's costs, but no more. In Switzerland, the hospital's operating costs are paid by combined contributions from the cantonal government and the sick funds. Since tax money is being used, the government's regulators refuse to allow any recipients to earn profits. The only ones earning profits in Switzerland receive no cantonal subsidies but survive entirely from private indemnity insurance and from self-payers.

Therefore, the for-profit hospital abroad can be profitable only from the way its owners use it:

1. The prospective budget approved by the rate regulators or by the sick funds' negotiators include lines for salaries that can be covered by the daily charge. The doctor-owner(s) include for themselves salaries as managers and as part-time chiefs of clinical services.
2. While the trend in public and nonprofit hospitals is toward full-time salaried practice by doctors, covered by an all-inclusive daily charges, the proprietaries still have fee-for-service practice. The doctor-owner(s) earn most of their personal incomes from their own billings of the sick funds and private patients. The proprietary enables them to perform more complex and more remunerative acts than they can in private offices.
3. Other physicians who are not owners must pay a considerable fraction of their fees in rental, to reimburse the hospital's costs and overhead. The participants are still left with more money than they could earn in junior positions in public or in nonprofit hospitals, and with more money than they could earn in private offices. And they gain a feeling of freedom.

Nearly all proprietary hospitals in Europe have been small, limited to the number of beds and specialties that can be handled by one or two owners. As public health regulations rise, requiring minimum numbers of nurses, standby physicians, and safety features, the small hospitals are squeezed. They can survive, if regulatory agencies or

negotiators grant them higher daily charges to cover the higher costs. Once forced by laws to pay them rates higher than those in the public hospitals, sick funds in France recently have been hostile and stingy.<sup>6</sup>

Proprietary hospitals can survive and even prosper under NHI, if the sick funds and regulatory agency are tolerant. But usually they cannot operate under the official program in a country where all operating funds are provided by the Treasury: government refuses to allow tax funds to be used to support an organization used extensively for a profitable private practice by the doctors. American Medicaid is the only exception authorizing tax money for profit-making hospitals and nursing homes, but the inevitable occurs: the organizations are constantly accused of corruption and profiteering, investigations of "Medicaid fraud and abuse" recur. Proprietary hospitals do not exist in Canada, since the public is satisfied with the established public and nonprofit hospitals, the public does not subscribe to private health insurance for basic care, and therefore no demand for private hospitalization is generated.

A small private sector exists in Great Britain, managed and financed entirely outside the National Health Service. It consists of about 1,000 small nursing homes and about 117 acute hospitals. Nursing homes have never been a benefit under the NHS, so they must be provided privately and paid for completely out-of-pocket. Private health insurance enables some Britons to pay for private acute hospitalization; companies pay for some private stays by their executives, particularly foreign companies; some private patients are affluent foreigners, particularly Arabs. Several private hospitals are nonprofits, much like the prewar British voluntary hospital. A few are profit-making, owned by British doctors, British businessmen, or American multinationals; they charge what they like and depend on substantial minorities of foreigners, as well as British patients. Like the American proprietaries, they survive only because they can send elsewhere -- to the NHS hospitals -- the patients who are poor and expensive to treat.<sup>7</sup>

In every other country, as in the United States, the proprietaries are not an alternative to the entire system of nonprofit and

public hospitals, but they are concentrated in certain regions. Since they are business firms, they cluster where the paying patients live and where the market is not being served by the other hospitals. In Britain, most private beds are in the south-east. In Germany, two-thirds are in Bavaria and Baden-Württemberg.

Chains. An independent proprietary hospital, however profitable, limits the horizons of the owners and managers. The executives give care to particular patients with a specific technology, they plow profits back in, their lives are bound up with the establishment. But, since Americans think of hospitals as an "industry," they have introduced the method of chain ownership common in other industries. Hands-off overview management is practiced from headquarters, return-on-investment becomes the measure of performance, services are added and dropped from individual hospitals to maximize their net profits, the chain managers calculate the gains and risks from expansions. The for-profit hospital chains become objects in the takeover frenzy in the financial marketplace.<sup>8</sup> Many of the financial speculators who buy and sell hospitals have no experience in health care and no understanding of the charitable and religious tradition that created hospitals.\* They have a strong personal interest in fighting all cost containment programs, whether national, state, or voluntary, since their aim is higher profit margins, not lower costs.

Europe has a long history of chains of hospitals with a common owner but they are always non-profit. Several hospitals may be owned by the same religious order, a few by the same voluntary association. They may share bookkeepers, the nursing school, and the purchasing office. If one runs a deficit, another may help out from its surplus. Such small nonprofit chains still exist in Germany.

The principal owner of private hospitals in Great Britain is such a nonprofit chain, viz., the Nuffield Nursing Homes Trust. At present, it owns 30 hospitals with 1,000 beds. It is run as a charity

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\*When Humana Inc. took over American Medicorp Inc. in 1978, the underbidder was Trans World Airlines. The most bizarre aspect of these events is that few (if any) on Wall Street thought them odd.

in the tradition of the prewar British voluntary hospital for patients who wish an alternative to the National Health Service. Patients are British, while most in English for-profit hospitals are foreign. Many patients have the less acute conditions that would place them on NHS waiting lists. Since the entire Nuffield chain is run as a unit, its hospitals can take in some difficult surgery with longer stays and offset it with many simpler and more profitable cases. Single autonomous private hospitals avoid the longer stay cases (such as hip replacements) and concentrate on the simple cases with short stays (such as hernias). Some patients are emergencies, such as appendectomies. Nuffield works in a circumspect manner with daily charges similar to the pay bed rates in NHS hospitals, and with NHS hospital consultants who treat privately insured inpatients at moderate fees. Patients incur much less cost-sharing than in the proprietaries.<sup>9</sup>

The one European for-profit chain, Paracelsus of Germany, operates financially somewhat differently from the Americans.<sup>10</sup> All its units are recognized by the provincial hospital plans and have negotiated normal daily rates with the sick funds. Otherwise, they could not survive. Certain items that are allowable costs in American cost reimbursement are not allowable in the German Selbstkostenblätter, viz., net profit; and principal and interest to repay loans incurred to buy land and established holdings. Therefore, the German chain must earn its extra cash in other ways: from the management lines in the budget, by sharing the private fees of the physicians. An American chain can accumulate large profits and investment money from the revenues of the member hospitals; for its takeovers, it can sell or trade stock. But a profit-making European chain can get extra money only from the owner's family wealth or his outside business interests. Paracelsus has recently bought proprietary hospitals and nursing homes in the United States -- the first European hospital owners to do so -- and should become an instructive laboratory in comparative hospital finance.

Comparisons. Admirers of proprietary hospitals point out their apparently lower unit costs -- for example, the Secretary of the Treasury quoted on p. XI-1, supra -- and some American data confirm them.<sup>11</sup> France and West Germany are the only developed countries where the proprietary

hospitals and surviving private clinics are substantial in number and market share, and therefore can be compared with the nonprofits and publics in costs. In my companion volume about France, I summarized the available information,<sup>12</sup> and following is a summary.

The proprietaries are smaller. They specialize in surgery and obstetrics, and they use their services more intensely, with shorter stays. They have greater continuity of care, since their inpatient attending physicians are also the patients' ambulatory doctors. Each proprietary has a larger medical staff than a public hospital, but fewer nurses; they economize by hiring fewer persons. The proprietaries cannot draw upon medical house staffs and nursing students. They do not perform the many educational, research, and welfare functions of the public hospitals.

The more complicated cases and the longer stays go to the French public hospitals. The public and proprietary hospitals exchange claims that each is less expensive than the other when treating the same case. The proprietaries have an advantage from the shorter stays and lower staff costs. Exact comparisons are difficult, because the public hospital bills by all-inclusive per diems, while the proprietaries debundle them, and the proprietary doctors bill separately. For short stays, many proprietaries may be less expensive (even including the doctors' fees) while some are more expensive in both cost per day and cost per admission. For long stays, the publics are more expensive, because each day is paid by a per diem averaged across all costs; but, exactly because long stays are less remunerative for them, the proprietaries avoid them.

Competition exists in French public policy. By offering comforts and the personal attention of doctors, the proprietaries attract middle class and upper class patients. The public hospitals have been pressed to modernize and "humanize," to improve their public image. The sick funds now squeeze the proprietaries in their bilateral negotiation, in order to put pressure on the public hospitals to lower their demands. The sick funds once disliked the proprietaries on ideological grounds but find them a convenient yardstick against the more expensively staffed and equipped public hospitals. Likewise, the German sick funds drive

hard bargains with the proprietary hospitals -- the latter could not flourish without contracts -- and then point to such low rates when negotiating with the nonprofits and publics.

#### TEACHING HOSPITALS

Issue. Nearly 1,000 American hospitals are owned by or affiliated with undergraduate medical schools. The medical school along with several other schools for health professionals are located within the hospital's sprawling buildings. Undergraduate medical students are trained in the hospital's wards, laboratories, and ambulatory clinics. Many chiefs of service have faculty appointments in the university; many of the attendings who teach undergraduates, interns, and residents have faculty appointments with special titles, such as "clinical associate professor." Many research projects are conducted in the laboratories and clinical services.

In addition, over 300 more have one or more residency programs. Altogether, about 18 per cent of all American hospitals are called "teaching hospitals."<sup>13</sup>

Difficulties. The result is lavish staffing, a constant flow of new equipment, and high costs. Because of the size and constant activity in a big medical center, it is difficult for the director's office to keep track.

Insurance carriers object to the high operating costs. A new or modernized hospital is financed by bonds amortized into the patient charges, developing teaching hospitals is exceptionally expensive, and therefore new debt service steadily increases the patient charges. The carriers say they are obligated to pay for care of their subscribers, not for the extra costs due to teaching. But, how to distinguish between clinical and teaching costs?<sup>14</sup>

A major teaching hospital does not merely give care to a certain number of patients, including more difficult ones. It creates new medical techniques. Who can say how high should be its capital and operating costs? If a planning agency denies a CON on grounds of excessive size and excessive cost, the university may use its connections

with the governor and state legislature to build it anyway. (An example is the approval of construction of the new University of Michigan Medical Center, after the HSA said that 888 beds and \$251 million in capital costs were excessive. At the time of writing, several New York teaching hospitals are creating the political groundwork to push through several billion dollars of new construction, despite a belief among planners that the city has too many beds and very high operating costs.)<sup>15</sup>

Payment of the physicians has been troublesome for Medicare, because Medicare has alternative payment routes that some hospital finance officers are suspected of using simultaneously. Blue Cross and other third parties try not to allow the salaries of any senior physicians in the daily rate, under the assumption their pay is for teaching and research. If the senior doctors have personally cared for the patient, they should bill by fee-for-service. But the wording of Medicare Part A has led the teaching hospitals to insist that the government pay salary costs; HCFA and the Senate Committee on Finance have complained that the hospitals were really billing for some of their teaching costs, and that the senior doctors were often paid twice, since the hospital also billed Medicare for Part B fees. The result has been over a decade of dispute. First, Congress commissioned studies to get the facts.<sup>16</sup> Then it tried to settle the problem by classifying hospitals into those where all doctors' incomes are salaries included in the daily rate (under Medicare Part A) and those where care is rendered by the senior physicians for fees (under Medicare Part B) (Section 227 of PL 92-603). But the political pressures from the teaching hospitals resulted in postponement of implementation of the law and its eventual demise through amendments.

New York State tried to distinguish the proportions of costs due to teaching and patient care in the payment of interns and residents. Citing the just-completed Institute of Medicine national survey,<sup>17</sup> the state's rate regulators estimated that 10 per cent of the house staff's time is devoted to studies, and therefore only 90 per cent of their salaries are patient care costs chargeable to Medicaid. Since the hospitals were left to find money that they had been getting, they followed the usual American solution, viz., going to court. In this

instance, they added the issue to a running series of law suits against the state government. A federal judge forbade the 10 per cent reduction on several grounds: HEW had confused everyone over the payment obligations under Medicaid by first opposing and then accepting New York's action; the state had not proved that 10 per cent of the time of its interns and residents is devoted to education.<sup>18</sup>

Evolution abroad. European and American medical education once was much alike. Chiefs of service made bedside rounds and explained patients to undergraduate students. Particularly interesting patients were presented in the large lecture hall. Practical lectures were also given in the autopsy room. The principal urban hospitals were the sites.

When American medical education became institutionalized, it evolved differently from Europe's. American medical students were older, with a stronger career commitment, and they were given much clinical education early. Many became interns and residents. Therefore many hospitals affiliated with the medical school, to teach both undergraduate and graduate students. A departmental structure was adopted in each field: several senior physicians were faculty members; many of the attending physicians taught by example.

In contrast, the teachers in European medical schools were few in number. Undergraduate students until recently were taught by lecture and not by clinical experience, so limited facilities were needed. The interns and residents learned by helping a chief of service, and their hospitals were not expected to maintain academic programs, with libraries, seminars, and other teaching apparatus. Until recently, much less clinical and scientific research was done in the European teaching hospitals.

Therefore, the European teaching hospitals were few in number and clear in identity. They were only those hospitals housing a medical school and run by chiefs of service with faculty appointments. They were often called "academic hospitals" or "university clinics"; one existed in each major city. But a few exceptions existed. If a country was large and nearly all its medical education was conducted in the capital city, the one medical faculty had many teachers and hospitals (as in Paris), or it had many medical schools, each with its own hospital (as in London).

Current methods abroad. Europeans and Canadians often encounter the same financing problems as the Americans. But they are often more inclined to live with some problems, on the grounds that no easy solution is evident, that tinkering aimlessly will create confusion, and the result will be worse. Europeans and Canadians seek principles and methods that can be easily administered for an entire country and therefore that can be easily understood.

In contrast, the Americans seem rarely to think of creating a national or large-scale structure. They think of health services -- like everything else -- as a melange of activities that can be inserted and revised individually. They are also eternal reformers. If a problem exists, victims complain and file law suits, political entrepreneurs rush to tinker and reap credit, judges grant equitable relief. Inaction results only from deadlocks among rival remedies, not from a presumption that an established arrangement should be made to work better, unless it is manifestly hopeless and unless a better substitute is evident. Controversial institutions, like health services, therefore are constantly reformed, making them more complex and less comprehensible.

The financial aspects of teaching hospitals are an example. Americans recently have tinkered and litigated frequently. Several new payment rules have been adopted, with varying fates. Europeans and Canadians are aware of essentially the same difficulties in financing the teaching hospitals. But they have kept simple arrangements -- some satisfactory because they avoid American difficulties and some unsatisfactory, but the unsatisfactory arrangements persist on the grounds that nothing better can be produced.

One very common arrangement that is simple and avoids requiring physicians to submit time budgets is the clear-cut assignment of clinical teachers. If a physician abroad holds an academic rank, he is paid a full-time or part-time salary by the university, and it is not included in the clinical costs of the hospital. Other items manifestly for formal education also are not included in the hospital budget, such as administrative and secretarial salaries and expenses for the school, the library, equipment and utilities for the classrooms, etc. All these are part of the university's budget, paid from the budget of the

national or provincial Ministry of Education, and ultimately derived from general taxation.

Every teaching hospital has extra costs due to extra tests and clinical activity performed for education and research. Teaching hospitals are invariably more expensive than the non-teaching, but the differences are not due entirely to the didactic work. Teaching hospitals practice "teaching hospital medicine" -- i.e., they receive the more complicated cases, those with longer stays. So it is not enough to match a teaching against a non-teaching hospital of the same size, and bill the Ministry of Education for the difference. The sick funds protest paying the full costs, so some resolution has been sought. Several countries first try to understand the facts by calculating the shares of the hospitals costs due to patient care and education:

1. Switzerland. The task is simplified by the usual method of assigning each doctor or hospital employee completely to either the clinical budget (paid by the cantonal Ministry of Health and the sick funds) or the educational budget (paid by the cantonal Ministry of Health). The task is further simplified, as in most of Europe, by clear designation of only a few hospitals as teaching centers, viz., the five large establishments with medical schools.

A committee of leading hospital finance officers was appointed by the Swiss Hospital Institute (SKI) to estimate the proportion of medical center operating expenses due to education. They compared the accounts of the teaching and the leading nonteaching hospitals. They estimated that, on the average, the additional cost in the teaching hospitals was about 33.4 per cent due to educational activity and about 11 per cent to "teaching hospital medicine" (i.e., the more difficult cases).

The actual shares are left to negotiations within each canton, but the SKI report is often cited as a guide. The sick funds always insist that the cantonal government pay at least one-third of the teaching hospital's non-salary costs, on the grounds they are educational and not clinical. Usually cantonal governments pay more, thereby picking up some of the clinical salaries in addition to the educational salaries. The Ministries of Health and Education then

conduct negotiations to settle their shares of the cantonal contribution to the hospital's budget. They argue back and forth about whether items in the budget are clinical or educational.<sup>19</sup>

2. West Germany. The medical school is owned by each provincial government Ministry of Culture and the university medical center is also owned by the Ministry. There exists, therefore, a presumption that their budgets are the responsibility of the Ministry. The medical school's many salaries and high costs are carried by the medical school and thence by the Ministry. Many employees and expenses of the hospital are attributed to the medical school too.

For the clinical costs of the patients, the university hospitals fill out the usual expenditure reports and prospective budget (the Selbstkostenblätter) and negotiate with the sick fund. If the province has several university hospitals, they compare notes with each other and with finance officers in the provincial government. One leads off the negotiations with the sick funds. What the hospital cannot collect from the sick funds, the Ministry must cover. The hospitals bargain for as much as they can get, while the sick funds argue that the high expenditure reports are padded by much activity that is really due to teaching. To resolve the impasse, several provincial Ministries and university hospitals commissioned studies of the costs of the centers, often concluding that between 20 and 30 per cent of the expenditures were due to teaching. The negotiations usually settled on a daily charge in the range of 70 to 80 per cent of the full daily costs, and the provincial government paid the rest.

The exact figures have varied from time to time, depending on the distribution of salaries between the medical school and the hospital, and depending on the affluence of the province. For decades after World War II, the provinces went overboard, pouring money into the universities, medical schools, and university medical centers. Several of the large medical schools and teaching hospitals (such as Munich) had total budgets of several hundred million dollars a year, only part (i.e., about three-fifths for much of the patient care costs) recoverable from the sick funds.<sup>20</sup> Recently, Germany's

economic downturn has led provincial finance officers to press the hospitals to limit the amounts they cannot recover from the sick funds.

3. The Netherlands. As in Germany, the seven teaching hospitals recently have been acquired by the Ministry of Education. In Germany, the owners are the provincial governments, and the methods of allocation between clinical and educational payers vary across the country. But Holland is unitary, and the single national Ministry governs the university centers. As in Germany, it is understood that the sick funds do not pay the hospitals' costs in full, and the division is settled by bargaining. What the Ministry cannot get from the sick funds, it must pay as part of its own expenditures from general taxation. The Ministry appointed an expert committee to estimate the proportions of costs due to teaching and due to education. The committee encountered much trouble in learning about the amorphous internal organization and accounts of these large enterprises. It had to guess on the basis of available records and -- without knowing about the Swiss research -- estimated that one-third of the hospital's costs are due to teaching.

The Ministry of Finance presses the Ministry of Education to charge the sick funds for all the rest. But in the past, the sick funds did not pay so much, and Education has found it politically prudent not to raise the charges too precipitously. As a stop-gap recently, Education charges the sick funds the same daily rate for all its teaching hospitals and it covers the rest from its budget.<sup>21</sup> Also, it pays the salaries of the staffs of the medical schools.

In a few countries (such as France and England), the educational Ministry has limited funds and a great increase in its medical spending is not possible. The patients and charitable donors have always covered all costs. As insurance replaced the donors, all costs continued to be pooled, and the sick funds paid for everything. A teaching hospital did not lack for some advantages: the nursing students were used on the wards, at salaries lower than the staff nurses. The salaries and office expenses of clinical faculty are paid by the Ministries of Education, but all the other expenses of the teaching hospitals are paid by the sick

funds (in France) and by the budgets of the Ministry of Health (in Britain and Canada).<sup>22</sup> Sick funds always protest about higher charges that are inflated by teaching costs, and CNAME has been appeased by a subsidy from the French Ministry of Health.

The entire issue fades in countries with Treasury financing: it does not much matter whether the taxpayer's money is routed through Health or Education, and Health usually prefers to be the sole channel so that its turf includes the country's most famous hospitals. In Canada, the provincial Ministry reviews and grants every hospital's budget individually, including every teaching hospital.

In Britain, the teaching hospitals are included in the lump sums that are allocated among regions and districts, and each District Health Authority has the difficult task of allocating the limited money between the teaching and nonteaching hospitals. British teaching hospitals were once affluent and politically powerful; the new merged structure of the NHS and the new financial allocation methods have been designed to compel them to fit into the country's clinical priorities. If clinical need and utilization are higher in nonteaching establishments, the teaching hospitals are squeezed. Decisions by the several tiers of planners and cash limits implementing them have forced the teaching hospitals to behave more like the others, specializing in certain fields, reducing the number of beds, and saving money for the higher-priority programs by shutting lower-priority activities.<sup>23</sup> Cutting back a teaching hospital is easier for public officials in such global budgeting for the entire health system than in bilateral grants between government and each hospital, as in Canada. Bilateral negotiations between sick funds and a teaching hospital (as in Europe) produce no cutbacks, since the sick funds are always expected to increase payments by some amount every year, because the teaching hospital can always get additional money from government, and because mixed financing makes it difficult for the payers to understand the internal financial affairs of teaching hospitals.

Teaching hospitals -- even if reduced in size and in number of services -- still remain more expensive than nonteaching hospitals under a vertically budgeted National Health Service, as everywhere else. Even when all the money comes from the Department of Health and Social Security,

criteria are needed to estimate the addition sent for each teaching hospital, in order to settle disputes between the Department and the Treasury's finance officers on the one hand and the hospitals' executives on the others. Besides their funds from the Ministry, every British teaching hospital gets a grant from another government agency, the University Grants Committee (UGC). But the hospitals argue this is still not enough -- the UGC formulae are said to short-change London -- and the Ministry adds a Service Increment for Teaching (SIFT) for regions and districts, according to numbers of medical students. The hospital does not automatically get a fixed addition, but each DHA acquires and distributes the SIFT allowance. As in other countries a research effort was commissioned to produce objective estimates of the additional activity and costs of all sorts, directly or indirectly traceable to undergraduate medical education. Econometric comparisons were made between teaching and nonteaching hospitals. They were also made between London and the provinces, to settle the controversy over whether the basic distribution formulae for all health services (RAWP) and for all higher education (UGC) seriously short-changed the London teaching hospitals.<sup>24</sup> The DHSS designed its SIFT in the light of the research, but it did not automatically adopt the researchers' numbers in the SIFT distribution formulae. Allocating is a normative decision about where the money should go, and a research project can only tell how it has previously been spent.

Because the European and Canadian payment systems consider the entire hospital according to general rules, they do not inflict upon themselves certain difficulties peculiar to the United States. Each American payer tries to limit its own liability and let the hospital find the rest of the money, even if other payers are overcharged. For example, in the Medicaid case, described earlier, New York State tried to limit its payment of the house officers' salaries to 90 per cent, on the grounds that the rest was education. Other governments might alter contributions but would make sure of an educational contribution from another source. HEW for a while approved the 90-10 division in New York while supporting payment in full in other states. In other federal countries, a national-provincial shared cost program has standard rules that apply everywhere.

These actions in New York added complications to the payment system and invited defeat in court.

Europe is integrating its teaching hospitals into the general hospital plans, so that expansion hereafter will depend on clinical need, and not merely the educational needs of the medical schools. I.e., new beds will not be added merely to give medical students and their professors enough cases in a wide range of specialties, if existing beds in nearby nonteaching hospitals are sufficient.<sup>25</sup> As I said, the teaching hospitals in Britain now are mixed into districts under global budgets along with nonteaching establishments, and the district managers in overbedded areas (such as London) reduce their beds and shut down some services, in order to operate the entire district under the cash limits. In countries without firm hospital plans (such as The Netherlands, Canada, and the United States) new teaching hospitals are erected and old hospitals are extensively modernized in areas already liberally provided, on the grounds that the medical school needs a better workplace. In Holland and the United States, planners have no leverage, since the medical schools and teaching hospitals can self-finance and amortize.

#### LESSONS FOR THE UNITED STATES

For-profit hospitals. The trend in all countries (including the United States) has been the disappearance of the solo doctor's small private clinic. It is too much trouble, and he can earn a good income from office practice or through hospital appointments. Patients now prefer the modern hospital to the private clinic.

Proprietary hospitals can survive if:

1. Official health insurance pays hospital charges and doctors' fees that are no lower than its payments to the nonprofits and publics.
2. Either:
  - (a) Cost-based reimbursers pay for a return on equity and for amortization of loans incurred to buy the building and land,
  - (b) Or, the proprietary can share in the fees of its doctors.
3. The economy is prosperous and hospital prices are not regulated. If an economic downturn occurs or if rate regulation is introduced, they

can be fatally squeezed. Therefore, many of their owners are very cautious.

4. A subtle relationship can be maintained toward the nonprofit and public hospitals. Enough such beds must exist so that the proprietaries need not take the poor and the long stays. But, on the other hand, there must be a shortage of comfortable beds in the nonprofit and public-acute sectors, to ensure business for the proprietaries.

Because the proprietaries need publicity to attract customers and because the mass media use them as a stick to belabor the nonprofits and publics, the proprietaries may seem to have a larger market share and a faster growth rate than they really do.

The proprietaries compete with the nonprofits and publics for only a small share of the market, viz., the short-stay acute cases in those parts of the country where the proprietaries cluster.

Teaching hospitals are large and amorphous organizations, a coalition of fiefdoms. It is very difficult to make accurate estimates of their expenditures, either in total or by cost center. The professors and researchers often find money and install services without notifying the finance office.

Even if all the figures were accurately recorded, it is very elusive to estimate the additional costs over a "normal" hospital due to teaching and due to the more complicated clinical work done at such an establishment. Elaborate research and statistical reports can move the third party finance officer and the hospital managers closer together and calm their rival arguments. But ultimately any division of sources of payment (e.g., between sick funds and government and between Ministry of Health and Ministry of Education) must be done through negotiations by common sense. Bargaining is a better way to run a system than a series of passionate ad hoc law suits. Since the allocation cannot be fine-tuned, complicated formulae can only invite uncertainty, disputes, and a futile search for refinements.

Research about the shares for care and teaching -- like any research -- can only tell how money has been spent. Policy-makers must decide how it should be spent. Therefore, the numbers derived from research need not be the same as the numbers in future divisions.

If changes are made in allocations or payment rates, one payer cannot decide them unilaterally without endless trouble and (often) defeat in courts and in legislatures. A coherent payment system requires an order by reallocation among all payers, often after long negotiations and compromises. A beneficial result is peace.

Medical schools and their benefactors will add many new beds, even if an area seems overbedded, unless the teaching hospitals become part of the general hospital plan.

## FOOTNOTES

1. Donald T. Regan, interview with Edward Cowan, The New York Times, Sunday, 18 October 1981, Section 4.
2. "Managing the System," The New York Times, 25 October 1981, special advertisement section about careers in health.
3. Bruce Steinwald and Duncan Neuhauser, "The Role of the Proprietary Hospital," Law and Contemporary Problems, Volume 35, Number 4 (Autumn 1970), pp. 818-827; David A. Stewart, "The History and Status of Proprietary Hospitals," Blue Cross Reports (Chicago: Blue Cross Association, Research Series 9, March 1973); and Lloyd L. Cannedy, "An Historical Analysis of the Viability of For-Profit Hospitals," Hospital Progress, Volume 51 (November 1970), pp. 64-71.
4. Data about geographical location and other characteristics are in Directory of Investor-Owned Hospitals and Hospital Management Companies (Washington: Federation of American Hospitals, annual); and Stewart, op. cit. (footnote 3, *supra*). The higher rate of closings among proprietaries than among others in the Northeast is illustrated in A Decade of Change in New York City Hospital Services (New York: United Hospital Fund, 1981).
5. 1981 Directory of Investor-Owned Hospitals and Hospital Management Companies (Washington: Federation of American Hospitals, 1981), pp. 13-17.
6. Glaser, Paying the Hospital in France, Ch. IX.
7. Glaser, Paying the Hospital in England, Ch. XI, pp. 20-26.
8. A description of management and medical care in one chain is Gwen Kinkead, "Humana's Hard-Sell Hospitals," Fortune, 17 November 1980, pp. 68-81. The American chains that are expanding abroad are described in Federation of American Hospitals Review, July-August 1981.
9. Glaser, Paying the Hospital in England, Ch. XI, pp. 22-24.
10. "In der Klinik neiderlassen?," Medical Tribune, 14 April 1980; and "Gleichzeitig Ärztehaus, Apparategemeinschaft und Krankenhaus," Arzt und Wirtschaft, Number 23, 1977.

11. For example, Duncan Neuhauser and Fernand Turcotte, "Costs and Quality of Care in Different Types of Hospitals," The Annals of the American Academy of Political and Social Science, Volume 399 (January 1972), pp. 52-54.

12. Glaser, Paying the Hospital in France, Ch. X, pp. 2-16. A research project comparing them is reported in Emile Lévy et al., Hospitalisation publique, hospitalisation privée (Paris: Éditions du Centre de la Recherche Scientifique, 1977).

13. A convenient description and statistics are in Toward a More Contemporary Public Understanding of the Teaching Hospital (Washington: Department of Teaching Hospitals, Association of American Medical Colleges, Revised edition, 1981).

14. Some attempts to estimate the educational costs are summarized in Medical Education Costs in Teaching Hospitals: An Annotated Bibliography (Washington: Department of Teaching Hospitals, Association of American Medical Colleges, 1981).

15. Oral Roberts' attempts to reverse the HSA's denial of a CON for a teaching hospital for his new university are described in Joseph Califano, Governing America (New York: Simon and Schuster, 1981), p. 146. Since he raised all the money and since the state government had the ultimate regulatory authority, he finally constructed the hospital and opened it in 1982.

16. Particularly Institute of Medicine of the National Academy of Sciences, Medicare-Medicaid Reimbursement Policies, March 1976, submitted to HEW, to the Senate Committee on Finance, and to the House Committee on Ways and Means (Washington: U.S. Government Printing Office, March 1976).

17. Ibid., pp. 21 and 162.

18. Hospital Association of New York State Inc. v. Philip Toia, 473 F. Supp. 917, 938-940 (1979).

19. Glaser, Paying the Hospital in Switzerland, Ch. VI, pp. 3-7.

20. In 1979, Germany's twenty-six Hochschulkliniken spent 6,340,900,000 DM. "Hochschulfinanzen 1979," Wirtschaft und Statistik, Number 7, 1981, p. 527.

21. Glaser, Paying the Hospital in The Netherlands, Ch. IV, pp. 8-10; and Ch. VII.
22. William Glaser, Paying the Hospital in France, Ch. VIII; and Glaser, Paying the Hospital in Canada, Ch. IX, pp. 8-9.
23. Glaser, Paying the Hospital in England, *passim*, esp. Chs. V and VII.
24. A. J. Culyer et al., "Joint Costs and Budgeting for English Teaching Hospitals" (York: Institute of Social and Economic Research, University of York, 1976). Published in part in A. J. Culyer et al., "What Accounts for the Higher Costs of Teaching Hospitals?" Social and Economic Administration, Volume 12, Number 1 (Spring 1978), pp. 20-30; and A. J. Culyer and M. F. Drummond, "Financing Medical Education," in A. J. Culyer and K. G. Wright (editors), Economic Aspects of Health Services (London: Martin Robertson, 1978).
25. Leaders of European hospital associations have been aware of the need to incorporate the teaching hospitals into the Ministry of Health's general hospital plans for some time, despite the control of such establishments in many places by Ministries of Education. Several essays in Methods of Cost Containment in Hospitals (Heverlee, Belgium: Hospital Committee of the European Economic Community, 1978).

## CHAPTER XII

### INVESTMENT

#### PROPER NUMBERS OF HOSPITALS AND BEDS

Issue. Some parts of the United States are believed by reformers to have too many beds. Occupancy rates may be low, but charges have to be kept too high to cover the fixed costs. Or, occupancy is kept artificially high by excessive admissions and prolonged stays. Care is given in the more expensive setting of the hospital when it should be given in less expensive and more pleasant surroundings, such as the outpatient department, doctors' offices, or the patients' homes.

A principal reason for the high costs of health care in the United States is said to be the sheer number of hospitals and beds. If there are too many beds, those costs are unnecessary. An excess of beds removes physicians' interest in finding less expensive alternatives.<sup>1</sup>

Difficulties. An initial problem is to define whether the country as a whole or particular regions have too many beds. Planners may postulate guidelines, such as 4 beds per thousand inhabitants. But if some communities will lose their hospitals, in order to bring the region down to the guideline, the citizens, doctors, and workers protest. The guidelines are said to be mistaken conceptually or inappropriate for an activity so spiritual as health care. Or, the affected communities seek extensions as special cases. Opponents easily riddled the Carter Administration's hospital bed-population guidelines.\*

The controversy revolved around the intent and powers of planning guidelines from the national governments. Providers and local groups complained that Washington was trying to order closings of their

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\*Congressmen from rural areas protested, and the guidelines were quickly revised to exempt them. This made facility-population ratios entirely meaningless. No guidelines need be heeded by anyone with political influence. The politically expensive dispute was one of the many episodes during the 1970's that wounded the executive branch.<sup>2</sup>

hospitals, an unconstitutional infringement on private property and on intrastate jurisdiction. HEW replied that it was merely giving advice and research data to HSA's. Action was voluntary by the HSA's and by hospitals. Establishments need not close but could convert to other purposes. A region could exceed a 4.0 per 1000 ratio with adequate reasons. Providers, local groups, and advocates replied that these substantive matters were no business of the national government.

If enough persons in the community think it does not have too many beds, and if the payment system enables providers to attract customers, new hospitals may be built even when the planners think there are already too many beds. By eliminating national planning machinery, the Reagan Administration will let "The Market" determine whether hospitals are excessive in number and capacity. But this raises all the questions that led to the creation of health planning. Will non-profit and for-profit hospital entrepreneurs overbuild beyond future needs, because they respond to short-term demand? Should they experience the pains of over-optimism (i.e., bankruptcy) and the windfalls of too little construction (i.e., the right to raise prices) like any other business firm, or should hospital affairs be more stable? If hospitals seem to have been overbuilt by some clinical definition of the population's needs, can the hospital owners and doctors keep the beds filled, regardless of the method of paying operating costs? Can any method of paying operating costs be designed to discourage patients, doctors, and owners from filling an "unnecessary" bed?

If an official planning decision concludes that a community has enough or too many beds, the problem then is implementation. New construction should be prevented, except for replacement. Existing excessive beds should be shut or converted to other purposes. Walter McClure's volume describes the methods suggested or attempted in the United States.

Evolution abroad. As in the United States, foreign hospital construction and conversions for centuries were left to the private sector. A few regulations about sanitation and safety were enacted, to protect the communities and the patients. Within these limits, each association and owner was allowed to build as it liked. Since it was

assumed that many potential patients were barred by scarcities of facilities and by financial barriers, any contributions were welcome. As national health insurance spread and personal incomes rose, increases in number of patients matched the growth in the number of beds. By the 1960's, all European countries had plenty of beds in acute and specialized hospitals, some exceeding the United States.

Misgivings arose about the costs during the 1970's. Governments and sick funds thought that too many beds were being kept filled by excessive stays. Overbedding would become worse, since the populations in most of Western Europe stabilized and began to contract. As in the United States, new agencies were created to plan the development of hospital services: they developed guidelines to define need; they classified areas that were overbedded and that still needed more; and several wrote detailed plans about all services in particular regions. In some countries, the planners were semi-autonomous public commissions (such as Holland); in most, they were civil servants in national or provincial Ministries of Health.<sup>3</sup>

#### CURBING GROWTH

Special investment funds abroad. The aforementioned plans identify areas where beds are sufficient. In several countries, all or a large share of money for new construction comes from public funds, either the general Treasury (Germany, Switzerland, Canada, etc.) or a special account kept by the sick funds (France).<sup>4</sup> The administrators of the investment funds are expected to give money only for projects explicitly authorized by or at least consistent with the plans. In these countries, new construction in overbedded areas has ceased; investment money is used for modernization there or for new construction in areas of continuing shortages.

Because nonprofit and public hospitals in Europe and Canada have become so dependent on public grants for completely new establishments or for expansion of existing ones, they cannot build new beds that the public authorities consider unnecessary. Exceptions occur from political pressures, to please communities with swing votes in a

forthcoming election or to avoid antagonizing an influential politician or local magnate. Then the case for the new facility is invented; it may be justified for its teaching value. But the planners are not overruled often, and few countries have much new construction nowadays.

Hospital owners and directors would rather be free of the investigations and disapprovals in the public grants, so they can build as they like. The American solution is to borrow investment money on the private capital market and then amortize principal and interest in the charges, as if the hospital were a typical private business firm. National health insurance programs usually do not include major construction costs in the statutory definitions of patient care costs to be borne by sick funds and itemized in the budget forms used for rate calculations. Traditionally, construction money was given by charitable donors. At most, several NHI programs recognize depreciation as allowable costs, where the depreciation is intended for small equipment used directly in patient care.

Self-financing. Under the unfettered arrangement favored by the hospitals, the Market decides. If the hospital managers think they can attract enough customers at high enough prices, they draw up construction plans and look for credit. If the banks (or other creditors, such as insurance companies) think the hospital will attract enough business at high enough prices, it makes the loan. The recent growth in American proprietary hospitals and the extensive modernization of the American nonprofits are due to the hospitals' ability to persuade the lenders that planning controls and rate regulation are weak, that demand will continue to rise in volume and in prices.<sup>5</sup>

The Netherlands is the only European country that finances hospital construction in this way.<sup>6</sup> The result in recent years has been a building boom and hospital cost inflation like America's but unlike the rest of Europe. This came as a complete surprise. Traditionally, Dutch hospitals were owned locally by municipalities and by confessional associations with limited financial capacities. Many towns had three small establishments: one Catholic, one Protestant, and one secular owned by local government. Amortization was traditionally included in the patient charges but was very low; new construction was infrequent and cheap, often based on charitable gifts.

The basis for a sudden change was the postwar laws instructing hospital price regulators to cover all costs, including debt. In theory, the Minister of Public Health is supposed to evaluate all applications for new construction, but the planning agencies have never agreed on guidelines to identify overbedding, and therefore the Minister automatically accepts nearly all applications. Many new schemes recently consolidated and increased the numbers of beds: the owners of old Catholic, Protestant, and public hospitals agree to merge and create a completely new establishment, with the same or slightly more beds. Since the rate regulation commission (the Central Agency for Hospital Charges or COZ) is obligated to set the patient care rates to recover full costs, including amortization, lenders readily supply the money. The operating costs for very new buildings plus debt service produces a high daily charge.\*

Implementing limits when hospitals can self-finance: the United States. Not giving a construction grant from a public fund is a simple way to prevent the building of "unnecessary" new beds. But how to prevent a hospital from exceeding the planned beds, when it can raise its own money, as in The Netherlands and the United States? American state governments, backed up by the national government, for years have required hospitals to obtain certificates of need before they could construct new beds or order new equipment. The CON's have been issued by state government agencies (usually SHPDA's) with advice of autonomous public boards supported by the national government (HSA's). They are implemented by the national government and by each of the state governments differently, demonstrating the peculiar features of the American form of federal government, viz., the overlap between the national and

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\*From 1957 to 1978, Holland reduced the number of acute hospitals from 269 to 233 but increased numbers of beds from 50,622 to 70,291. (The number peaked in 1972 at 71,779 and has slowly declined). The total costs of the hospitals greatly increased because of trends found in all countries (personnel, technology, etc.) but experienced particularly intensely in Holland, because of the extensive transformation. Total expenditures on acute hospitals in millions of guilders rose from 355.3 in 1958 to 7856 in 1978; guilders per patient-day rose from 20.40 in 1958 to about 355.70 in 1978. The rate of change was greater than in neighboring countries, even those (like France) with higher inflation rates.

each state government, and the variation among state governments.

1. National government, under Section 1122 of the Social Security Laws, governing payments by Medicare, Medicaid, and Maternal and Child Health. If a CON has been denied for construction of a building or acquisition of equipment, the third parties will not allow capital costs (amortization and depreciation) in the payments. But its operating costs are allowable.
2. Every state can enforce the CON as it pleases. In theory, opening new services without a CON can be "illegal," but sanctions vary. An important innovation is the screening and approval process: instead of inventing a scheme secretly and borrowing the money to go ahead, the hospital must submit a detailed proposal to the HSA and SHPDA, and all interested parties (other hospitals, consumers, and payers) can comment. Proposals are tailored to what will likely be approved; the HSA and SHPDA can press competing hospitals to cooperate.

The controls over investment are weaker than they seem:

1. Section 1122:
  - (a) Only capital costs of a disapproved item are excluded from the Mediplan third party payments; other operating costs can be recovered, and the comparatively trifling capital costs can be loaded onto other payers.
  - (b) Sanctions apply only if a CON is denied. So, hospitals do not file applications if they anticipate denial, and state governments with permissive administration of CON do not alert the Medicare fiscal intermediary or the state Medicaid bureau. The hospitals then treat Mediplan patients anyway with normal reimbursement.
  - (c) Section 1122 must be enforced by the Medicare fiscal intermediary. But the fiscal intermediary is usually another third party payer, interested in charging as much as possible to Medicare, lest it bear the underpayments.<sup>7</sup>
2. State governments:
  - (a) They vary widely in strictness. But even the most stringent (such as New York and Massachusetts) have had to make concessions

because of the immense political power of the hospitals. In a showdown, the state legislature can grant CON's over the opposition of the planners (as in Massachusetts) or might even repeal the entire planning system. SHPDA's are always threatened by reversals by judges imbued with the philosophy of the freedom of the business enterprise. A determined hospital can recast its proposal and eventually gets full or partial approval.<sup>8</sup>

- (b) The conservative assault on the feeble American hospital planning laws included research that supposedly demonstrated that, where the CON did restrain further overbedding, the money was spent anyway on equipment. Therefore CON did not reduce costs.<sup>9</sup> Actually, the trends about fewer beds and much more equipment were worldwide, and neither CON nor any other regulatory system "caused" them.
- (c) A common complaint in American state rate-setting agencies is that they are not represented sufficiently in the planning decisions of the SHPDA's and HSA's. CON's are granted because the purchase costs appear low, but the annual operating costs are very high.<sup>10</sup> Connecticut now lodges CON authorizations and rate-setting in the same commission, and a few states (Massachusetts and Washington) now involve the rate-setters in the CON review.

One solution to lavish building through self-financing is to improve hospital planning by strengthening its political base and its techniques. The Reagan Administration's opposite solution to the disappointing experience with CON is to take government out of the subject completely -- no more definitions of overbedding, no evaluation of projects, no CON's -- and leave everything to the hospitals, the lenders, and the Invisible Hand.

Implementing limits when hospitals can self-finance: foreign methods. Several features of the American CON experience are unlikely abroad, because they deviate from general practice in finance and in regulation:

1. Payers need not pay for unlicensed services, but only for those

licensed. Therefore, they would not have to pay merely for a service whose CON was denied, but for any service that had not been given a CON.

2. If a license were denied, payers would be relieved of payment of all the operating costs, not merely the capital costs.
3. Usually in federal systems abroad, the provincial government alone and not the national government deals with hospitals and other health care providers. If they did, their principles of regulation and payment to the same provider would be identical.
4. Provincial governments would be more consistent in procedures and in implementation.

Self-financing is the method of a powerful hospital industry and may be associated with a strong veto of the CON process itself. The European country relying most strongly on self-financing, viz., Holland, has been unable to implement CON's so far because it relies on agreement among the interested parties to supply the guidelines.<sup>11</sup> The Minister of Public Health approves or disapproves new construction, on the basis of a provincial hospital plan written by regional governments, implementing guidelines written by the College of Hospital Planning. The College is one of the autonomous public agencies found throughout the Dutch social system: it consists of the interest groups themselves, such as the sick funds, the national hospital association, several other interest groups in health, and impartial experts. The interest groups have never been able to agree on anything so divisive as the definition of the overbedding threshold, the provincial planners have never been able to start work, and the Minister has never had a basis for rejecting a new hospital scheme. Most proposals replace existing beds in a more expensive way, and therefore the Minister rarely is presented with a great increase in beds in each project that might be underutilized.\*

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\*As a general principle, the reduction of overbedding is national policy,<sup>12</sup> even if the government is uncertain about how to accomplish it. A general norm of 4 beds per 1000 inhabitants has been recommended in government reports, but it is advisory until official plans are written. The professional staff of the College has written research reports about particular cities (such as Amsterdam) that provide expert opinion about the location and specialties of overbedding, and these are used by the hospital association in guiding voluntary mergers.

The total number of beds in the country slowly drifted upward until 1972 and has even more slowly declined since then. Once a proposal is approved, all financial risks end: the sick funds are obligated to pay daily charges that cover both operating costs and debt service. However, if a hospital seems to have oversold its case, and utilization is not as great as expected, it cannot expect to avoid all pressures, it cannot automatically get whatever rates will guarantee its high costs, since the rates are awarded by a regulatory body. Even without clear-cut planning guidelines and even with a statute obligating it to award rates that cover all operating and self-financing costs, the COZ examiners use their discretion less generously with hospitals that seem to have expanded unduly beyond a normal growth in demand. As long as the beds are filled, the new hospital prospers, and COZ cannot use rate regulation to cut them back.

Holland's experience demonstrates several problems in hospital planning in general and in the forms of implementation that rely on the hospitals' own initiatives:

1. The targets are uncertain. Decisiveness was hindered not merely because the hospital associations and sick funds had conflicting interests, but because the definitions of future need are uncertain. Collegial groups, such as public commissions, cannot easily build a general consensus under such conditions.
2. In the absence of clear-cut facts, everyone in health (particularly in the recent past) tries to play safe by avoiding shortages. At the time public commissions and individual government planners considered future bed needs, they projected contemporary conditions into the future. Holland then had the highest birth rate of any developed country, a low death rate, and low prices. A widespread belief -- even among payers -- was that the country's population would grow substantially and could afford new hospitals. But the population did not grow and costs rose.
3. Planning and constructing a hospital is a long-term event. When hospitals finally opened, some encountered less utilization and higher operating costs than they expected. In other economic markets, business firms can enter and adapt more quickly.

4. No hospital is like an isolated business firm, and it does not fully self-finance. The community and local governments observed the mergers and new plans. Lenders often asked local governments for guarantees of the loans and always got them.
5. It is much easier to expand services than to limit them, and much more difficult to reduce them. In a system of self-financing and consultative commissions, no one agency has much leverage.

If enough interest groups and public agencies can make a clear-cut decision in a European country, then it is implemented, at least against new entrants. A sick fund cannot be forced to pay a complete hospital (in contrast to a single service) if it has been built in defiance of the consensus. But that can happen in the United States. The U.S. Supreme Court recently invoked the antitrust laws to force Blue Cross of Missouri to pay for care in a hospital that had been built without a CON, because state and national planners had judged the area overbedded.\* The Supreme Court demonstrated the unique capacity of American judges to rewrite a law through interpretation:

Nothing in [PL 93-641] requires Blue Cross to take an action that, in essence, sought to enforce the advisory decision of the HSA. HSAs themselves are required to seek private cooperation only "to the extent practicable" [citing a clause in the law originally intended to authorize implementation by private payers]. And there is no reason to believe that Congress specifically contemplated such "enforcement" by private insurance providers, let alone relied on such actions to put "teeth" into the noncompulsory local planning process. Congress expected HSA planning to be implemented through persuasion and cooperation.

In (for example) Germany, the sick funds are obligated to pay for care only in those hospitals listed as necessary in the provincial

\*National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City et al., 69 L.Ed. 2d 89, 101 S. Ct. 2415 (1981). The State of Missouri had not yet installed its CON and Section 1122 programs; but, as an interim measure, had authorized insurers to implement its policies when signing contracts with hospitals, a common procedure in Europe. In other countries, governments do not intervene before judges in opposition to implementation of their own hospital finance laws. One of the bizarre features of the Gerimedical case was the filing of an amicus curiae brief by the Reagan Administration on behalf of the hospital and against Blue Cross.

hospital plan. If a patient goes to an unlisted hospital, he must pay directly and seek reimbursement. Some sick funds pay nothing, others small indemnities to avoid antagonizing their subscribers. Because patients will have out-of-pocket expenses with them but none with listed hospitals, the unlisted ones have low charges.\*

A problem for American state regulators is their limited voice in CON awards, but investment and rate decisions are coordinated more closely in other developed countries. Coordination is very close and operating consequences are very salient if both the investment grants and operating budgets are given by government, as in Switzerland and Great Britain. In both, proposals for new buildings, equipment and services are supposed to include predictions of future operating costs, and the predictions affect the approvals.<sup>13</sup> In several Swiss cantons, the hospital's investment request is accompanied by a formal request to add whatever new personnel will be required. The French hospital's annual budget report to the prefecture includes pages for expected investments as well as expected operating costs, and the DDASS examines both when awarding the new rates.<sup>14</sup>

But coordination may be weak in Europe as in America, if neither the planning nor rate regulation agencies are government line departments, and if the hospitals can push the investment to completion by self-financing. An example is The Netherlands.

#### REDUCING BEDS

It is difficult to find levers in national health insurance to reduce overbedding -- i.e., to induce some hospitals to close completely and to induce others to close some beds. The hospitals under national health insurance are owned by local governments and by private persons, who try to keep all the beds and induce the sick funds to pay for their operations in full.

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\*In America, a hospital operating without a CON has much better chances of survival. Blue Cross reimburses the patient but at a high rate -- for example, if Blue Cross of Kansas had won its case against Gerimedical, it would still have been committed to reimburse a subscriber at 80 per cent.

At times a major change is made in hospital finance, lists of participating establishments are redesigned, some hospitals are excluded, and others are included at a lower bed level. For example, the German Hospital Finance Law of 1972 provided capital grants by Bund-Land cost-sharing to all hospitals approved as necessary in provincial hospital plans. Sick funds were obligated to negotiate with them all-inclusive daily charges that would cover their economical costs. A widespread perception was that Germany had far too many beds, and the plans seemed the opportunity to reduce them. Many hospitals were not listed in the plans, particularly small private clinics but also some confessional establishments, if better equipped public hospitals were in the same area. Some were listed for smaller bed sizes and fewer clinical services. The excluded hospitals would be squeezed and could not survive. Since they would not receive any investment money from government, they would have to pay for it in their revenue from patient care. The sick funds were not obligated to pay them as generously as the recognized hospitals, if at all; the excluded hospitals would have to rely extensively on private payments.

Beds were reduced in Germany, but not as stringently as expected. Confessional associations and doctor-owners are well connected in provincial politics and persuaded Ministries of Health to add their hospitals to the lists. Where the planners started very tough, as in Bavaria, great political uproars followed, and many compromises were made.<sup>15</sup> The sick funds were bound to accept them.

All German provinces have hospitals with incomplete coverage: a specific number of beds are in the plan, the extra ones are not included in the formulae for government investment grants, and the sick funds are bound to pay only daily charges calculated over the planned beds. This should induce the hospitals to drop the extra beds. But it is too complicated for the hospital to calculate its costs only for the planned beds. Germany lacks a neutral regulatory office empowered to examine the hospital's records, and the sick funds lack access to the books. So, in practice in these hospitals, the sick funds must pay a daily charge applying to all patients and beds, but they try to get a low price.

Americans search for formulae that will be disincentives to excessive beds, that will be incentives for reductions, that will not depend on the "arbitrary" judgments of regulators, and that will satisfy judges' standards of "equity." Rate regulation in New York now assumes that operating costs are 80% fixed and 20% variable. If a hospital increases its patient-days over its volume in 1978, a formula allows the hospital to bill Blue Cross and Medicaid for only 20% of the average daily charge for those extra days; if the hospital decreases its patient-days below the 1978 volume, it may still bill Blue Cross and Medicaid 80% of the saved days. Normally a daily charge system yields payment in full for every additional day beyond the number in the denominator of the formula, thus providing an incentive to overservice; and it causes loss of the full daily charge for every reduction in stays, thus creating deficits and providing an incentive to avoid improvements in efficiency. The New York formula -- like others devised for specific programs -- is supposed to discourage prolongation of stays and protect the hospital against loss from shorter stays. The hospital would not lose but would achieve a more stable financial base if it reduced its listed bed capacity to the new lower occupancy level.<sup>16</sup>

European payment systems have always avoided complicated formulae, on the grounds their outcomes are uncertain, perverse results can occur, and disputes are invited. No European system has the enormous volume of appeals and law suits that overwhelm the hospital rate regulation system in New York. However, European reformers are baffled about how to accelerate the shortening of stays. Stays gradually decline, but not yet down to the American figures. Average number of days per stay in acute hospitals have been:\*

|               | <u>1965</u> | <u>1977</u> |
|---------------|-------------|-------------|
| Netherlands   | 18.5        | 14.4        |
| Switzerland   | 16.6        | 13.9        |
| France public | 20.0        | 13.1        |
| West Germany  | 20.0        | 16.3        |
| Great Britain | 13.4        | 9.5         |
| United States | 7.8         | 7.6         |

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\*Numbers are slightly overstated for a few European countries, such as Holland, where many hospitals count both the date of admission and the date of discharge separately in the stay.

One method of reducing beds is merger of several old hospitals, to produce a new one. But this is possible only where new construction exists. Holland is the leading example. Delicate negotiations occur among the small confessional and public hospitals, so that none feel annexed by another. In Amsterdam, the local hospital association helps the negotiations. Usually the Ministry or planning agency is involved, since it must ultimately license the new construction. The new hospital sometimes results in fewer beds but always seems to result in higher unit and aggregate costs.

Another method of reducing acute beds is conversion to another purpose. Then the hospital workers and community cooperate. This requires inclusion of extended care under national health insurance, since the usual conversion creates nursing homes from small acute hospitals. Such conversions have occurred widely in France. But the method has not been used to alleviate acute overbedding in Germany, since nursing homes are not covered under NHI. As a result, the elderly fill beds in German acute hospitals.

The most effective system for reducing beds is the direct one: one organization owns, manages, and finances all the hospitals. To save money, it shuts the less efficient, the less safe, and the less used hospitals. If it wants to operate a new hospital without spending more money, it must close an even larger number of old beds. This has been the experience of the National Health Service in Britain during the last two decades. Budget constraints are tight and money for all health programs is pooled. Growth money is concentrated in those districts that had too few facilities in the past. In most of the country -- particularly in cities with declining populations and plentiful facilities -- any new programs and hospitals must be offset by economies, primarily by shutting entire small hospitals, by reducing less used services in big ones, and constructing a division of labor. Shutting and rearranging hospitals cannot be done merely by giving an order, even in these unified arrangements. Hospital managers will not resist the government that appoints them, but the labor unions and communities protest. The government must provide the workers with new jobs and transportation to get there; and it must demonstrate to the community that the new and more distant establishments are better than and as accessible as the old.<sup>17</sup>

If a country's hospitals are privately owned, if self-financing is not possible, if all hospital financing and planning come from a single source, that source can add to beds in some places and halt growth in others by granting and withholding investment money. But the unified payer-planner cannot so easily use finance to reduce beds. It cannot order the hospital managers to cooperate, since the managers are independent of government and are affiliated with the owners, doctors, and communities who want no change. An example is Canada, where provincial Ministries of Health have found their financial power insufficient without management control. All provincial Ministries pay all operating costs of hospitals in full with annual global budget grants. In theory, if a Ministry decides that a community has too many beds, it could give certain hospitals less money. Ontario starting in 1979 planned to give hospitals smaller increases if they were in overbedded areas, in order to motivate them to contract and to achieve regional goals of 4/1000 and, later, 3.5/1000 in eastern Ontario and 4.5/1000 in Western Ontario. This precipitated many arguments and appeals between the hospitals and government; it precipitated noisy protests by citizens and workers -- orchestrated by the managers -- in areas where the squeeze led to visible closing of services and of entire hospitals. Many concessions were made to buy peace. The Government-of-the-Day was unwilling to fight every claim, since it had a precarious majority in the legislature and new elections loomed. Hospitals had on the governing boards many local elites with influence inside the governing political party. More broadly, cooperation seemed a better way to run health services. So, many deals were struck: hospitals with acute beds over the regional guideline got sufficient operating budgets if they converted some capacity to long-term care.

#### EQUIPMENT

Issue. The economy of hospitals is complex because they are both technology-led and labor-intensive, they combine both advanced and simple services. The elaborate equipment brings in many new programs and clinical specialties, calling for modification or expansion of the

building, more power and other support, additional specialized medical, nursing, and technician personnel. Basic nursing care, food service, laundering, and other simple work also have become more intense, and many more personnel have been added for them too.

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In every country, the acquisition and operation of new equipment add to the operating expenses of a hospital, both in their own costs and in the additional personnel.<sup>19</sup> Questions arise whether the new methods accomplish anything, or whether their adoption is merely a fad.<sup>20</sup> If they are effective for some purposes, are they used to excess? Are equipment and programs located in appropriate places, or are they spread out wastefully?

Whether new equipment and new methods are employed prematurely and too widely is a particularly difficult issue in the United States. Every hospital is independent and competes for doctors and patients. The most desirable doctors insist on the newest devices, and hospitals install them. The hospitals borrow the purchase money: both doctors and hospitals are financially motivated to use the new equipment to the maximum, the doctors to earn fees, and the hospital to pay off the debt. Some uses of the new equipment may be unnecessary and (in the hands of non-experts) dangerous. Because of the large and lucrative national market, many instrument companies arise and compete to persuade doctors and hospitals to install their products. The prestige of a hospital now rests on its technology and specialized services, no longer on its size, and the result is much higher costs, both in total and per patient-day. A hospital loses financially by maintaining excess capacity, but it gains by putting its money into new services.

Difficulties. Fundamental dilemmas are raised but not resolved. Should American health services make a commitment -- as they have implicitly in recent decades -- to try to prolong life for all by all possible means? That policy implies the current pattern of rapid implementation of new technologies and their very widespread installation. As a result, costs steadily mount faster than the rest of the American economy, and much of American technology is diverted into medicine. If a policy is to control costs, what patients should be denied advanced care, or should length of care be limited?<sup>21</sup>

It is difficult to judge the merits of specific devices in the short run, when the decisions must be made about development and deployment. Technology assessment in medicine is much more puzzling than technology assessment in other fields, because the nature of success in medicine is so uncertain.<sup>22</sup> How can one balance the costs and benefits, particularly when the accomplishments of a technique are definite but modest? Instead of rejecting a promising method, shouldn't the instrument companies and doctors be encouraged to use and improve it? If a technique does well, should massive investment be applied to making it even better -- also a fundamental dilemma in that other life-and-death field, national defense.

Doctors and hospitals want the newest equipment on the ground that "newer is better" -- a principle coequal to that other principle of medical care, "more is better." But whether or not the newer accomplishes more than its predecessor, it is usually more expensive in purchase cost and in operating cost. Unlike private industry, medical instrumentation is rarely marketed to do the old task at lower cost. Sometimes when it is, as in the case of automatic biochemical analyzers, the lower unit cost is achieved only if the volume is very high, and the result is higher costs for the system as a whole. New equipment is introduced at an accelerating rate, and doctors press to replace the "old" items before they are worn out and fully paid off.

Once hospitals bought much of their equipment as well as their buildings from cash given by donors. After World War II, philanthropy did not rise as fast as purchase costs. Hospitals persuaded Blue Cross to include depreciation of existing equipment in daily charges, enabling hospitals to accumulate replacement funds. Eventually depreciation was included in the allowable costs of Medicare and Medicaid. Much of the profits earned from self-payers have been placed in the equipment funds. By the 1970's, a revolution had occurred in capital financing: most equipment was purchased from the hospital's own funds rather than from donations.<sup>23</sup> Pressure from doctors to buy new equipment and its rising prices contributed to the rise of hospitals' operating costs and charges. As doctors pressed for shorter useful lives, the acquisition costs accelerated.

The competition among hospitals for new services and equipment, and their ability to buy it through self-financing defied any planned allocation. Federal and state planners tried indirect controls, like Certificate of Need, but CON applied only to construction and the largest equipment. Most equipment was exempt as too small individually, and CON was never designed to review entire programs.\*

Passively funding the entire depreciation pool left the initiative with the hospital. A few state regulatory programs, such as Maryland and Washington, attempted to come closer to controlling the total annual investment for each hospital by agreeing to a capital fund in each hospital's approved budget in lieu of depreciation, but they still could not review the hospital's specific uses.<sup>25</sup>

Self-financing made the hospital's finances and prices depend on the vagaries of the capital market. This was a reason why hospital charges defied voluntary and governmental cost containment policies during late 1980 and 1981. Hospitals' average interest costs during the first five months of 1980 were 12.1 per cent higher than the comparable period during 1979; they were 27.1 per cent yet higher during the first five months of 1981. (All inpatient expenses per admission from all sources each May showed a 15.0 per cent increase from 1979 to 1980 and 18.2 per cent from 1980 to 1981.)<sup>26</sup>

Evolution abroad. As happens in many situations, foreign and American hospitals once acquired new equipment in the same way -- i.e., by gifts and grants -- but the United States then developed methods that gave the hospital managers and doctors great independence from donors, from sick funds, and from governments. When patients paid little or nothing, neither foreign nor American hospitals could self-finance from operating revenue. All new equipment required a donor or a special fund drive.

\*State CON programs have had widely different cost thresholds in reviewing proposed new equipment. They have been much stricter in controlling beds. The richer states were the first with CON and during the 1970's exhibited an apparent paradox: beds diminished, equipment and service intensity greatly increased, and total costs increased even more than in the states that were poorer and had no or more permissive CON's.<sup>24</sup>

This remains true in most countries: an important new piece of equipment is paid for in cash by a government agency, by a special public capital fund, or by a special loan. However, a few countries have adopted self-financing in the private capital market, as in the United States.

Self-control and social control -- i.e., planning both within the individual hospital and for the entire community of hospitals -- are common abroad. The United States is comparatively diffuse within as well as outside the hospital. In most countries, prioritizing of requests is the rule at some stage; in some, calculations about long-term cost consequences are made, in addition to the immediate purchase price.

Current methods abroad: preparing applications. Once the purchase of new or replacement equipment in European hospitals was a free-for-all, although limited because of the modest development of both equipment and funding. Each chief of service decided his needs and asked members of the governing board or outside donors to supply them. Unified equipment planning and fund-seeking have become the rule, but the chiefs are still somewhat autonomous in some (not all) teaching hospitals. They have prestige and professional independence as professors; the teaching hospital may be very large and still built in the pavilion design, and the director's office cannot know what is going on everywhere; the chief can raise his own research contracts and instrument companies may give him, lease, or sell their devices cheaply.

But a more coherent method is now common. To get a grant from the government Treasury (as in Britain, Canada, and Switzerland) or to get a low-interest loan from a public investment fund (as in France),\*

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\*Once French public hospitals covered most investments by grants from governments and benefactors, but they now can draw on public revolving funds that are midway between grants and borrowing in the commercial capital market. The national government has large reserves from its tax collections, the sick funds large reserves from their premium collections. The hospitals must apply by formal procedures, as if they sought grants. They must repay the money with low interest, but the DDASS automatically includes the repayment costs in higher daily charges. French public hospitals are beginning to borrow from banks, but the DDASS continues to monitor them closely, and they cannot become as independent as a self-financed private hospital.

the hospital's governing board must apply. Therefore, all wishes of the medical staff and of the housekeeping departments must be presented to the director's office with careful documentation and they must be prioritized. In Chapter XIII of this report, I will describe how medical staffs have had to organize for such decision-making. When the director (in the name of the governing board) sends the application papers to the grantor, it is clear that the choice represents a consensus.<sup>27</sup>

Equipment falls into about three levels of magnitude, each with different application procedures. The thresholds among levels are defined variously in different countries:

1. The most advanced and most expensive items, such as CAT scanners, open heart surgical units, renal dialysis centers. Acquiring one implies creating a new service with substantial operating costs. Countries with public investment funds usually have national facilities plans specifying the types of hospital best suited to house such programs and the size of the catchment area. The hospital can make its case for one. Often the national planners approach the hospital and suggest an installation. The rate regulators and sick funds readily grant the higher daily charges to a hospital, if the installation accords with the plan. Often use of the facility is paid for by a special fee per item of service, paid to the hospital by the sick funds.
2. Larger equipment must be prioritized by the medical staff, and special requests are sent to the grantor by the hospital. It is presumed that every hospital gets a certain amount every year for improvements in its capital stock. If the purchases seem appropriate to that type of hospital, each hospital gets whatever it requested within the total money available to it. The funds, planners, and rate regulators let each hospital's medical staff and management set the priorities.
3. Smaller equipment purchases are usually replacements. They do not have to be applied for individually and formally. The hospital's prospective budget always includes a small amount to replace lower-priced items and to buy new ones, and every daily charge collected

from insurance carriers and self-payers includes a contribution to this fund. The hospital's director, housekeeping department heads, and medical chiefs of service divide up the fund as they wish.

As in the case of new construction and modernization, mentioned earlier, a common problem in the United States is said to be the neglect of operating outcomes during investment decisions: a new item may seem "cheap" and may even be "given free," but new personnel, power, supplies, and activity are permanently added. Staffs of American state rate-setting commissions complain that the SHPDA's grant CON's for new equipment as well as for buildings without thinking of running costs,<sup>28</sup> and the rate-setters must then increase prices.

Allocation of major equipment, regionalization of programs.

A very large piece of equipment does not stand alone but is the focus of a special program. Public authorities abroad are always aware that they are really approving the creation of a new clinical program, transforming that hospital and permanently increasing its staffing and budget. The question is whether some public authority has power to control or influence, or whether each hospital can develop its own program and find its own money. When the public authority has power, it must develop a policy. If government provides all the money for investment and for operations -- as in Great Britain, Canada, and (for investment) Switzerland -- it can easily decide where new heavy equipment is located. Usually they are placed in regional centers; in practice, usually in the teaching hospitals. If a regulatory agency must approve before the hospital can get a grant or low-interest loan from a special public capital fund, it can approve only those applications that would create regional centers in that specialty.

Policy is never frozen. During the 1970's, for example, the national government of France approved purchases of head- and full-body CAT scanners only by regional centers. Money would be saved; work would be done only in the teaching hospitals that had expertise in many fields. The new government of François Mitterrand wished to decentralize France in health services and in other sectors, and it wished to build up technology and professional competence in the medium-sized cities. So, in 1981, it sent out new guidelines to the prefectures, authorizing them to

approve purchase of CAT scanners by medium-sized hospitals. Altering the guidelines did not produce an indiscriminate spread: purchases were constrained by the financial capacities of the public investment funds.

Self-financing. When the hospital can borrow to purchase whatever equipment the doctors want, plans and restraints hardly exist over the location and costs of technology. If there are controls, they are limited to major construction. For example, CON in the United States is limited to buildings and to exceptionally expensive equipment. During the wave of opposition to health cost regulation of the early 1980's, the equipment threshold is being raised to exempt almost every item in almost every state.

In The Netherlands, the hospital planning laws once applied only to construction, and all equipment could be bought and amortized as the hospital wished. The only restraint was whether COZ recognized the new service and its higher costs in the prospective budget and daily rates, but usually it did. The sick funds then were compelled to pay. The hospital planning laws have been amended to give the College the power of prior approval over major equipment that will introduce new services, but implementation has been cautious. The many ordinary new acquisitions still do not require prior approval.<sup>29</sup>

Self-financing is associated with greater initiative by the individual chief of service and an absence of a rigorous prioritizing machinery for the entire medical staff. In Holland, the chief of service usually writes out his request and discusses its merits with the hospital's managers. Many requests may be discussed at plenary meetings of the medical staff. The managers and governing board then decide the ones to purchase from borrowing or from any capital fund they have maintained.

In the absence of a rate regulator, as in most of the United States, the hospital management and the lender negotiate the final arrangement. The management decides whether its total debt (including the new ones) could be carried under its new rate structure, whether the new equipment would pay itself off by generating enough new revenue. In Holland, as in the United States, hospital managers and governing board vary in strategy: some establishments are willing to carry more debt

than others, some are willing to increase debt while others are not. Lenders investigate whether a hospital is overextended, whether it can repay under its prospective rates. Local governments in both the United States and Holland clinch the loans by guaranteeing them.

Some Dutch hospitals are very expansionist, as the doctors press for the newest methods and as the managers seek a modern image, and they confront the restraints of COZ rate regulation and of the sick funds' financial limits. Every year, the governing committees of COZ negotiate guidelines about the desirable increases in hospital costs, including investment and debt. Recently the Ministry of Health has recommended limits in the annual rate increases. When reviewing the doctors' requests for new equipment and new services, the hospital managers and governing board calculate how much of the additional debt they can carry within the automatic annual increase granted every hospital by COZ, how much additional total revenue will be generated by greater utilization under the normal inpatient rates, how much additional revenue will be generated through the outpatient department, and how much extra must be obtained in a special application to COZ. If the hospital thinks it can justify the new service and higher costs before COZ, it borrows the money and buys the equipment. The managers become skilled in anticipating the verdict of COZ, since it is the key to growth; if they guess wrong and COZ does not grant the full request, the hospital is saddled with its new debt and must make compensating economies. Too much heat rests upon the COZ examiners, and the managers and service chiefs of the very modern hospitals can usually make a plausible case to get what they want. But rate regulation has some restraining effects: the hospital does not buy equipment that will not be utilized profitably, it does not buy so much in a year that the rates will have to increase far beyond the COZ guidelines.

Technology assessment. One American technique absent abroad is technology assessment. The presumption that an innovation is ineffective unless effects are proved, statistical measures to disprove the null hypothesis, double blind experimental design to prevent bias in favor of the innovation arise out of Anglo-Saxon empiricism. It has been the Americans who implemented these ideas in the study of social

innovations and the effects of widely diffused techniques. Americans created evaluation research in the social sciences and created technology assessment. Their goal is to condition purchase of new equipment by hospitals and approval of installation by regulators upon research reports about the safety, efficacy, and cost-effectiveness of each item.

Technology assessment hardly exists abroad, and no reports about the effects of the new equipment are used in the decisions to request and purchase. Reports are used, but they are the manufacturers' literature. When a request is rejected, the reason is limits in funds.

(Drugs are dangerous enough so that European countries must have some licensing of sale and some monitoring to remove a troublesome item. But, as in the adoption of technology, doctors and hospitals are more free abroad in prescribing drugs. Compared to the United States, the regulatory agencies make fewer demands that a new drug must accomplish something, do not block introduction until carcinogenic effects on experimental animals are excluded, insist on fewer double-blind experiments, and rely on delicensing after use at least as much as on screening before introduction. European regulators believe they can pull a drug off the market quickly, because the medical profession is more structured, many drugs are prescribed only by specialists, and the relevant physicians can be contacted quickly. But FDA always worries that any doctor can prescribe once a drug is approved, that controls and communication work badly in a big and diffuse country, and that controls are possible only before marketing.)<sup>30</sup>

Drug regulation in the United States is directed from the center and is strict. Technology regulation is decentralized into the hands of SHPDA's, HSA's, and lenders of money, and it is weak. Research about medical technology assessment in the United States is not converted into controls, and the National Center for Medical Care Technology proved one of the Reagan Administration's more docile victims. Therefore the United States has been the world's laboratory whereby the medical profession and the instrument companies develop, spread, evaluate, and perfect new technology. The most profitable and clinically

useful devices are then marketed in the smaller European markets.\* Weaker drug regulation makes Europe the world's laboratory to develop drugs and perform the mass trials. Because drug testing is cheap and Europeans readily take pills, the European market can easily bear the costs.

Influencing the acquisition and use of expensive equipment by the design of fee schedules. The use of equipment by the hospital is usually part of the total budget and the all-inclusive daily charge, where that method pays for care of individual patients. Usually its use is not covered by item-for-service fee schedules. When this occurs -- as in the case of ambulatory care in physicians' offices or in group health centers -- the sick funds can discourage unnecessary installation and over-use by reducing the fee per act, thereby eliminating windfall profits.

The hospitals that can be affected by these methods are the proprietaries, since -- in some of the few countries where proprietaries are common -- the bills are broken into a nursing-hotel daily charge, tests, use of the operating room, and the doctors' personal fees. When autoanalyzers began to spread throughout Europe, ordering entire test series became very profitable, since the fees were written for the time when technicians personally did the tests.\*\* After the incomes of

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\*Only a market as large and as uncontrolled as America's could pay for the mass testing. The CAT scanner was invented by an Englishman (Godfrey Hounsfield) and developed by his British employer (EMI Ltd.), but it was a financial albatross for the company. Numerous sales at high prices were not possible in Britain, because the National Health Service bought expensive new technology slowly and spread it thinly among regional centers. The market was in the United States, but American companies rapidly mass-produced and spread scanners. EMI lacked the capacity to mass-produce in its own factories and to market throughout the United States. The American companies earned enough to retain skilled lawyers to fight off EMI's indignant law suits over patent infringement.<sup>31</sup>

\*\*Blue Cross in America considers unnecessary tests on admission one of the principal unnecessary costs. Combatting them is one of the priorities of the Voluntary Effort. Blue Cross and Blue Shield pay only for tests certified by a physician as "medically necessary," in order to eliminate the costs of tests ordered without clinical need by a doctor or by a machine.<sup>32</sup>

pathologists and of private hospitals skyrocketed from the laboratory tests, sick funds in several countries negotiated with the medical association a double fee schedule, viz., higher for tests done by technicians, lower for the entire automated series, lower for any individual test done mechanically.<sup>33</sup> The sick funds discourage the performance of advanced surgery (such as open-heart) anywhere except in the public and nonprofit hospitals by limiting fees only to honoraria and by not including high practice costs. Therefore, the surgeon cannot save enough money from the fees to amortize loans to equip a very expensive specialized operating room in his private clinic. The proprietaries specialize in simpler surgery, using cheaper equipment and requiring shorter stays.

#### LESSONS FOR THE UNITED STATES

Plans and regionalization can be implemented only if the planning agency controls the money for construction, major modernization, and large equipment that generates new services. In practice, planners are not taken seriously if hospitals can be created and expanded without prior approval.

If hospitals can borrow money and use it for new development, they can do almost as they please. Rate regulators usually allow amortization in the new rates, except when the new facilities are flagrantly under-utilized and when the increase in rates is far beyond the general norm. Expansionist hospitals learn how to lobby to get the greatest scope. Sick funds go along with the rate increases, provided the regulators' actions help them get more income.

Retrospective sanctions through disallowances in the rates are rare and thus ineffective. To have any effect at all, they must apply to inclusion of all the disapproved item's operating costs in the rates, not merely its capital costs. They must apply to all payers, and not just a few, since then the hospital can collect the costs from others.

Rate regulators are oriented toward increasing payments more or less. Applying squeezes is difficult, because of uncertainty over their judgments about overprovision and because of political opposition.

Usually rate regulators lack the legislative authority and tools to force cutbacks. Closing beds is less common than converting them to other purposes, after subtle negotiations with planners and rate regulators. Extensive closings are possible only under full government ownership, and then only if officials can demonstrate to the population that new and better facilities have been substituted.

If a hospital must get investment money from a public granting agency, it is usually pressed to justify the application with statements of need, future personnel requirements, and future costs. If the public planning agency invests its own money, it is more cautious about future utilization than if it merely authorizes private investments. The rate regulators are less likely to complain about poor coordination with the agency reviewing facilities, less likely to complain about excessively expensive long-term commitments made by someone else.

If a hospital must get investment money from a public granting agency, usually the hospital's medical staff is reorganized so it can fix priorities. Under self-financing, each chief of service is more of an entrepreneur and tries to persuade the directors and governing board about the clinical merits of the new scheme, but without mundane projections about utilization and costs.

Hospital managers prefer self-financing if they want to be autonomous and are ambitious to out-race the others. The construction and equipment industries prefer self-financing, so they can deal only with the chiefs of service and with the hospital managers, and so the prices will not be set by a public agency.

## FOOTNOTES

1. On the number and distribution of beds in the United States and the desirable reduction from 4.4 per 1000 to 4.0 per 1000, see the influential report by a committee of the Institute of Medicine, Controlling the Supply of Hospital Beds (Washington, D.C.: National Academy of Sciences, 1976), esp. pp. vii-ix and 7-16. The definitive methodological analysis of the measurement of overbedding and the measures to remedy it is Walter McClure, Reducing Excess Hospital Capacity (Excelsior, Minn.: InterStudy, 1976).

2. "National Guidelines for Health Planning: Advance Notice of Proposed Rulemaking," Federal Register, Volume 42, Number 185 (23 September 1977), pp. 48502-48505.

3. Described in Health Planning Methods: Report and Case Studies of the 1978 International Workshop (Washington: Bureau of Health Planning, U.S. Department of Health, Education and Welfare, 1979 and 1980, 3 volumes).

4. William Glaser, Paying the Hospital in Switzerland, Ch. IV, pp. 4-9 passim; Paying the Hospital in Canada, Ch. VIII, pp. 2-10; and Paying the Hospital in France, Ch. IV, p. 4, and Ch. X, pp. 22-31. A monograph about German capital investment is now being prepared by Theo Thiemeyer, University of Bochum.

5. The remarkably rapid shift from grants to self-financing in American hospital investment is described in Paul B. Ginsburg, "Resource Allocation in the Hospital Industry: The Role of Capital Financing," Social Security Bulletin, October 1972, pp. 20-30; and Lyman G. Van Nostrand, "Capital Financing for Health Care Facilities," Public Health Reports, Volume 92 (November-December 1977), pp. 499-507.

6. Glaser, Paying the Hospital in The Netherlands, Ch. IV, pp. 5-8; Ch. V, pp. 10-12; Ch. VI, p. 25; and Ch. XI, pp. 8-11.

7. The befuddled implementation of Section 1122 is described in Evaluation of the Efficiency and Effectiveness of the Section 1122 Review Process (Washington: Lewin and Associates, 1975).

8. Reversals of CON decisions occurred in 17 per cent of all bed expansion projects and 7 per cent of all CAT scanner applications in the rare study reported in Paul C. Nutt and Robert Hurley, "Factors that Influence Capital Expenditure Review Decisions," Inquiry, Volume 18 (Summer 1981), pp. 155-156.

9. David S. Salkever and Thomas W. Bice, Hospital Certificate-of-Need Controls (Washington, D.C.: American Enterprise Institute for Public Policy Research, 1979).

10. For example, in papers by Harold Cohen and others, describing experiences of the Maryland Health Services Cost Review. For an exasperated proposal that no new hospital should be granted a CON without divulging its complete proposed operating budget, see John S. Cook, "A Discussion of the Causes of Hospital Cost Inflation" (Baltimore: Health Services Cost Review Commission, 1977), pp. 20-21. For a proposal for a model state rate regulation law combining capital planning, hospital-licensing and rate-setting in the same agency, see Carl J. Schramm, "A State-Based Approach to Hospital-Cost Containment," Harvard Journal on Legislation, Volume 18, Number 3 (1981), pp. 647-649 and 672-674.

11. Dutch hospital planning is described in H. A. M. Elsen, "Planning Inpatient Facilities in the Netherlands," in Health Planning Methods: Case Studies from the 1978 International Workshop (Washington: Bureau of Health Planning, U.S. Department of Health and Human Services, 1980), Volume 2, pp. 143-164; and Glaser, Paying the Hospital in The Netherlands, Ch. XI, pp. 8-11.

12. In the influential Structuurnota Gezondheidszorg (Leidschendam: Ministerie van Volksgezondheid en Milieuhygiëne, 1974), Secs. 6.1.3. and 7.3.1.

13. Glaser, Paying the Hospital in Switzerland, Ch. IV; and Paying the Hospital in England, Ch. VI, pp. 2-10.

14. Glaser, Paying the Hospital in France, Ch. IV, pp. 4-5 and 9-13.

15. Described in Fritz Schnabel, Politischer und administrativer Vollzug des Krankenhausfinanzierungsgesetzes (Konstanz: dissertation for the doctorate in social science, 1980), pp. 68-110 and 157-172.

16. Hirsch Ruchlin et al., "Cost of Hospital Care and Third Party Payer Reimbursement," New York State Journal of Medicine, March 1981, p. 414. Earlier formulae appear in Abt Associates, National Hospital Rate-Setting Study: Case Study of Prospective Reimbursement in New York (Washington: Health Care Financing Grants and Contracts Reports, 1980), pp. 20-21.

17. Glaser, Paying the Hospital in England, Ch. V, pp. 21-26; Ch. VII, pp. 18-23.

18. The part-timers and low-wage employees have increased in number even more than the technicians, according to Martin Feldstein and Amy Taylor, The Rapid Rise of Hospital Costs (Washington: Council on Wage and Price Stability, 1977).

19. The effects of new equipment on operating costs of individual installations and of American health care as a whole are summarized in Medical Technology: The Culprit behind Health Care Costs? (Washington: National Center for Health Services Research, Proceedings of the 1977 Sun Valley Forum on National Health, 1979).

20. The leading iconoclast is Archie L. Cochrane, Effectiveness and Efficiency (London: Nuffield Provincial Hospitals Trust, 1971).

21. The history of hospital technology and the policy choices are presented in Louise B. Russell, Technology in Hospitals (Washington: The Brookings Institution, 1979).

22. Ronald G. Evans, "Can Technology Assessment Control Costs?," Health Care in the American Economy: Proceedings of a Conference Sponsored by the Blue Cross and Blue Shield Associations (Chicago: Health Services Foundation, 1980), pp. 100-105; and Medical Technology: Urban Institute Conference (Washington: National Center for Health Services Research, Research Proceedings Series, 1979). The NCHSR monograph describes the problematics and methods of technology assessment for several purposes.

23. Ginsburg, op. cit., and Van Nostrand, op. cit. (both footnote 5, supra).

24. The research about the impact of CON is summarized in Urban Systems Research and Engineering, Certificate of Need Programs (Washington: Health Resources Administration, Health Planning Bibliography Series No. 12, 1978).

25. John S. Cook, "Discussion Paper for Capital Reimbursement" (Baltimore: Health Services Cost Review Commission, 1977); and Diane E. Hamilton et al., Case Study of Prospective Reimbursement in Washington (Washington: Health Care Financing Grants and Contracts Report, 1980), pp. 14 and 41. Maryland's controls were stricter than Washington's and suffered a common fate in American hospital rate regulation: the hospitals took the Commission to court and won an order weakening the controls.

26. Data on Community Hospital Indicators, Office of Public Policy Analysis, American Hospital Association.

27. The planning and allocation of equipment grants in France are described in Glaser, Paying the Hospital in France, Ch. IV, pp. 4-5 and Ch. X, pp. 22-31; and David Banta et al., The Implications of Cost-Effectiveness Analysis of Medical Technology: The Management of Health Care Technology in Ten Countries (Washington: Office of Technology Assessment, 1980), pp. 105-114.

28. For example, Harold A. Cohen and Carl J. Schramm, "A Model for Resolving Planning-Rate Setting Conflict" (Baltimore: Maryland Health Services Cost Review Commission, paper for a conference sponsored by the American Enterprise Institute, 1980), p. 16.

29. Glaser, Paying the Hospital in The Netherlands, Ch. IV, pp. 5-7.

30. Comparisons between Europe and the United States in the adoption and distribution of both technology and drugs appear in Banta, op. cit. (footnote 27, supra), pp. 194-199. Instead of being "captured" by the drug companies, FDA has been very critical, and the industry has accused it of creating a "drug lag" in adoptions and sales, years behind European competition. Gerald D. Laubach, "Federal Regulation and Pharmaceutical Innovation," in Arthur Levin (editor), Regulating Health Care: The Struggle for Control (New York: Proceedings of the Academy of Political Science, 1980), pp. 60-80; and John Kelly, "Bridging America's Drug Gap," The New York Times Magazine, 13 September 1981, pp. 100-108.

31. The contrasting time series in the spread of scanners in the United States and Britain are graphed in Banta, op. cit. (footnote 27, supra), p. 206.

32. Voluntary Effort Quarterly, Volume 3, Number 2 (June 1981),  
pp. 5-8.

33. Glaser, The Doctor Under National Health Insurance:  
Foreign Lessons for the United States (New York: Bureau of Applied  
Social Research, Columbia University, 1977, report for the Social  
Security Administration available from NTIS), Ch. XI, pp. 67-69. No  
such variable payment methods are used in the American Voluntary Effort,  
which is indeed supposed to be "voluntary."

## CHAPTER XIII

### PERSONNEL

#### LABOR RELATIONS

Issue. Traditionally, American hospitals depended on dedicated women who worked long hours at very low pay. Hospitals became accustomed to an authoritarian management and a docile labor force. Many of its blue collar employees were unemployable elsewhere. As blacks and Latin Americans moved northward, hospitals came to rely on them. As in the prewar British voluntary hospital, many American hospitals were ruled by the community elite and by the doctors in a patronizing style.

Since workers, nurses, and junior doctors were supposed to serve and not speak, staff organization had no place. Unions belonged in factories but not in hospitals, where they violated the natural harmony. Agitation over wages and house were thought to divert workers and nurses from their true calling. Organizing drives and strikes for higher wages and shorter hours were unnatural intrusions. Hospital staff and patients should be protected from these manipulations by outsiders. If a union attracts any support, it is only because of errors by management, and therefore business consultants and hospital associations should instruct management about methods of keeping the union out.<sup>1</sup> Since fighting union recognition protects the patient, the costs of the campaign should be included in the contractual allowances charged to payers.

Government for many years protected the unions' opportunities to win recognition in other industries, but not in hospitals. Until

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Because hospitals are labor-intensive and because wages make up a large proportion of the budget, labor relations and wage determination are central issues. The subject is big, with many methods and lessons from abroad. A special research project merely devoted to this subject would be very rewarding. The following pages give a few highlights.

1974, the National Labor Relations Act was interpreted as not covering public and nonprofit hospitals, and therefore managers did not have to recognize or bargain with unions as a uniform national policy. Each state government handled matters differently. In practice, most non-profit hospitals were allowed to resist unionization on the grounds they were charities. Finally in 1974, the National Labor Relations Act was extended to the private nonprofits. The NLRB has excluded all interns and residents from coverage, by defining them as students and not employees.<sup>2</sup> The national government includes in allowable costs for Medicare and Medicaid the hospital's costs in influencing employees not to join unions. (When HCFA tried to reverse the policy in the 1979 edition of the Provider Reimbursement Manual, the American Hospital Association filed a law suit, and HCFA backed down).<sup>3</sup>

The ingenuity of managers, the docility of many workers, and the legal barriers have left hospitals one of the least unionized industries. Fewer than 20 per cent of the private nonprofits and less than 10 per cent of the proprietaries have any union contracts, totalling only 20 per cent of all hospital employees. The numbers increase slowly. Each contract covers only some of a hospital's employees; not many hospitals have the full set of contracts covering everyone. Unions are more successful in the governmental hospitals, since they can influence government to cooperate. Unionization is concentrated in a few states of the Northeast, the Midwest, and Pacific Coast. Occasional strikes occur, but many hospital employees stay at work, picket lines are crossed freely, and wage gains are modest. In other American industries unions become influential by incorporating shared controls over work rules and job security in contracts, but hospital managements retain almost complete control over job definitions and assignments of personnel.

Difficulties. Most hospital managers experience little "trouble," since unions are absent or unrecognized. A few have unions to deal with in contract negotiations and in grievances. Occasionally management must face pickets.

At the moment in hospital labor relations, no national pattern exists: many entire states have no unionization and collective agreements at all, and many areas even in more unionized states have none. Bargaining units need no longer approach hospitals according to the heterogeneous laws and machinery of the states, but the 1974 NLRA amendments have not resulted in a substantial increase in unionization and in collective agreements; the amendments have not resulted in uniform national patterns.

From the standpoint of the unions the difficulty is rivalry. Only the state nursing associations seem to have a "natural" constituency and have members in many hospitals throughout the country. Many other unions are active, trying to recruit members and to negotiate with hospital managers; many are based in other industries (such as government employees and teamsters) and recruit whatever hospital workers will join; few are active beyond one region; none have a monopoly on one occupation, not even the state nurses' associations. The proliferation of organizations contributes to the disorder, the hesitation of workers to join, the limited commitment by the state and national labor leaders, the bargaining strength of management.

From the standpoint of many hospital workers, the situation doubtless is frustrating. (I hesitate to generalize, without attitude surveys of hospital workers.) There is plenty of evidence of complaint in big cities, about wages and status. Many nurses drop out of practice, and urban hospitals depend heavily on foreign nurses. Many hospital workers are contented, of course, even if some are fatalistic rather than enthusiastic. Many hospital employees in suburbs and towns are not principal breadwinners; they are wives working part-time to supplement their husbands' incomes. Many workers continue to get psychic income from hospital work, since they are devout church-goers; but doubtless they would be even happier with more cash income too, particularly since the most conspicuous class of hospital workers (the doctors) uses the organization to get rich.

The greatest difficulty for hospital finance may be only potential, but it is real, in the light of foreign experience. Unionization in American hospitals raises wages between 5 and 20 per cent, at

least initially, when the unions get their first contracts in each hospital. The effects of unions on raising wages vary by occupation: highest for health aides and technicians, lowest for service and maintenance workers, lowest for nurses. American hospital unions may not be powerful enough to keep wages substantially higher thereafter than the upward trends occurring simultaneously in the minimum wage laws and in market forces.<sup>4</sup> The laws about minimum wages and maximum hours at present may be at least as important as union activity in protecting American workers in this traditionally underpaid and once overworked industry, simply because they affect all employers and workers, while the unions do not.

Hospital workers' hourly wages started far below those of comparable occupations, since the hospital workers earned less money for longer hours. The hospital workers since World War II in the United States -- as in every other country -- have risen faster than comparable workers.<sup>5</sup> But they still remain below other workers in much of the United States. American hospitals have gotten steadily more expensive, and the non-wage costs -- i.e., capital, administration, medical supplies, etc. -- have been rising even faster than the payrolls. As a proportion of all hospital operating costs, payrolls and fringe benefits steadily declined from 66 per cent in 1960 to 60 per cent in 1979, despite a growth in the number of employees. All other developed countries rose steadily from less than 60 per cent in the 1950's to between 66 per cent and 80 per cent today.<sup>6</sup>

The United States therefore has managed to develop the world's most expensive hospitals in the absence of the forces that correlate most strongly with hospital costs abroad, viz., strong unionization and linking of wages. Therefore, perhaps America's biggest hospital cost explosion is still to come.

American hospitals had long been accustomed to economizing in wages, and the fledgling hospital unions were determined to end this. A fundamental showdown arose over rate regulation. If the hospital had to operate within a limit, did the limit prevent the unions from getting accelerated wage increases, to enable hospital workers to catch up? The unions had to gain political leverage over governments. Wage

pass-throughs have been included in New York State's rate regulation and in the Carter Administration's hospital cost containment bill. The ostensible grounds were that the individual hospital did not negotiate the wage agreement and had to accept it. Other states left to the judgment of the regulators the inclusion of higher wages in the rates. Massachusetts required hospitals to operate within the ceilings even if new wage agreements were signed by the hospital association; the hospital was expected to reduce its personnel. In most of the country, each hospital set its own wages -- either by management decision alone, or in conference with the employees' council -- and regulators felt that the individual hospital could be held responsible.

Evolution abroad. Once hospital employment in Europe and Canada was much like the recent American situation. In Catholic and Protestant confessional hospitals, the leading staff members were members of religious orders who served very long hours at no personal pay. The image of the hospital was humanitarian and self-sacrificing; all hospitals attracted persons motivated for spiritual gratifications, committed to serve. Trade unions were fighters for the working class against capitalist exploiters; they usually ignored hospital workers, who were not perceived as wage-workers used by industrialists for their own enrichment. The only class of hospital employees that was organized was the professional nurses, but their associations were small, oriented toward service ideals, and only slightly concerned with wages and hours.

After World War II, civil service unions arose, with a spirit and purposes different from the industrial unions. They were not fighting the capitalists for a bigger share of their own output. They sought to guarantee that their members would receive no worse than prevailing hours, wages, fringe benefits, and contracts. They were interested in improving working conditions and the management of public employment. They were as interested in new laws regulating public and nonprofit employment, as in contracts. The new unions by the 1960's had added sections for hospital workers; in some countries (such as France and Switzerland) many were public employees, in others the nonprofit hospitals seemed so analogous to public employers that the civil service unions seemed natural homes. In contrast in the United States, a greater range

in union types attempts to organize hospital workers, resulting in great rivalry and (often) a strident tone arising from the industrial unionism of some.

Meanwhile, other sectors of the economy in most continental European countries were moving toward nationwide multi-employer collective bargaining, sometimes even industry-wide. All regional unions formed national headquarters; all national federations joined in a few national confederations. The union confederations negotiated new contracts -- including wages and hours -- with the national confederations of employers. Some details were added in regional negotiations, after national pacts were signed. Except in Great Britain -- and, decreasingly even there -- the basic contracts and the essential supplementary details were not negotiated at the levels of company and plant.

The public service unions in continental Europe negotiated for hospital workers in the same way. They sought favorable regulations and wage levels each year from the French national government, covering all employees in the hospitals owned by the communes. And in other countries, they sought favorable contracts with the national association(s) of hospitals.

The principal unions are accepted as the legitimate spokesmen for worker interests throughout the industry. Exact membership size does not determine whether an officially recognized union participates in negotiations. A European union therefore need not engage in the frenetic activity to make sure it wins certification and decertification elections, as under Taft-Hartley.<sup>7</sup> If several unions have members in the hospital staffs, all are represented on the labor side of the bargaining table; the largest leads the negotiations. The unions do not depend exclusively on dues; some are paid by political parties or religious associations.

Structured wage determination in Europe. During the 1950's and 1960's, hospital labor conditions and wages were integrated into the familiar patterns of multi-employer collective bargaining. The one or several national unions representing hospital workers formed one side. The one or more hospital associations formed the other; in some countries, separate associations existed for public, nonprofit private, and for-profit private hospitals, or separate associations for secular, Catholic

and Protestant associations. If there are several hospital associations, the unions meet first the one representing the most prosperous and/or most numerous hospitals, and then try to close the same deal with the others soon after. Or, all the associations form a negotiating committee, as if they were a single national confederation. In a federal system like Germany, the national confederations representing the hospital workers negotiate basic principles with the hospital associations; associations of both sides in each province then adopt the principles and add details in the contracts that actually bind the hospitals.

In every European country, the unions representing government employees meet the representatives of the personnel and finance Ministries every year. They negotiate the design of the salary scale for use throughout government; actually, each year they alter certain categories in the long-established scales and revise rules for assigning occupations to categories. The two sides also discuss the financial value of the basic point which, when multiplied against the points for each category, determines the wage for that category next year. (For example, the francs and centimes for the French salary scale.) Besides getting favorable details about employment and money in the face-to-face negotiations with the civil servants in the personnel and finance Ministries, the unions also seek occasional legislative improvements through their political allies in the Cabinet and Parliament.

In countries with a substantial number of public hospitals, such as France and Switzerland, the hospital workers' unions meet representatives of the Ministry of Health every year to settle job definitions and assign occupations to categories in the wage scale. Actually, they revise long-established regulations. They also revise or add many other job definitions, fringe benefits, etc. When the currency value of the basic point in the wage scale is announced by the Head of Government, all government employees learn their pay for the year, including all the hospital workers, employed nurses, and employed doctors. Unitary countries like France follow the same rules and salary scale for the entire country, but federal countries decide them provincially. The unions then try to get the same terms of service and wages from the private hospitals.

Most governments have incomes policies or anti-inflation policies that recommend annual rates of increase. Unions and business in the private sector cooperate unevenly, but public service unions and hospitals usually are more cooperative. The government's announcements about the income limits and anti-inflation guidelines usually come at the end of the preceding calendar year, and the announcement of new civil service wages during the spring, in preparation for the annual national budget. The civil service pay increases are close to the guidelines, and the sick funds everywhere automatically accept them in the public hospitals' daily charges. Rate regulators always pass through the wage awards; if they constrain the individual hospital's personnel spending, the issue is an excessive number of employees.

The private hospitals try to negotiate wage awards that stay close to the government's incomes or anti-inflation legislation, since anything more might be resisted by the sick funds.

By the end of each annual round of negotiations, everyone is covered: nearly all hospitals; all jobs in them; all employees, including all junior doctors and the salaried senior staffs. As in the rest of the economy, negotiations and contracts do not depend on elections to designate a particular union as bargaining agent, but they proceed in order to make equitable and peacefully accepted decisions. I.e., the need to decide wages, hours, and terms of service by a method other than unilateral management dictation automatically assigns to the task the principal unions for hospital workers without special recognition elections. Usually substantial agitation occurs throughout a country when the unions first press government and the hospitals to substitute the negotiating system for management dictation. Once the system is adopted, negotiations each year are usually quiet and businesslike. However, if the hospital workers seek a big improvement in their contracts -- such as the junior doctors and nurses in Germany during the early 1970's -- they may parade in the streets and strike. Street parades in Paris by the hospital workers -- either alone or in association with other government employees -- are a customary part of the negotiating scenario each year in France.

The wage outcomes are never predictable within an American hospital, results in each place are slightly different, and the annual increases are not standard. Management is stronger within each hospital in the United States; skillful individual managers can often drive hard bargains (with individual workers in nonunionized hospitals and even with unions), subject only to the constraint of attracting enough workers. At times average hospital workers' pay in an area rises faster than that of comparable service workers, at other times less. National averages show more or less than parity at various times, but the averages conceal many local variations.<sup>8</sup>

Continental Europe's wage system has tried to eliminate this flux. The hospital occupations are given parity with other public service occupations by their location on the governmental wage scale. Occasionally the annual negotiations move a hospital occupation slightly upward, but usually relationships are stable. The public wage scale until the late 1970's was linked to averages of private sector wages and the latter were often indexed to consumer price indices; or, in some countries, the public sector wages were indexed directly. The explosion of inflation after 1972 throughout Europe persuaded many governments to back off from direct or indirect indexing; more recently, civil servants receive raises within guidelines from the Cabinets, often influenced by negotiations with the public service unions. Regardless of the basis of the general increase, the hospital workers always move with the rest of the public service. If a hospital manager needs to economize, he must become more productive, with fewer employees; or he must substitute persons with lower skills. He cannot pay lower wages.<sup>9</sup>

The European manager has many things decided for him: he does not negotiate labor contracts, and wage awards are almost automatically passed through. An American hospital manager has more to manage. He can coordinate his wage and price decisions. The drawback is that some strict rate regulators expect the American to squeeze his personnel budget, even if tension occurs in the staff. The American Vice President for Personnel must devote much time to external relations and organizational politics; his European counterpart has primarily internal tasks and a simpler life.

Fluid industrial relations in Britain. As in other matters, the other Anglo-Saxon countries have shared some common features -- and problems -- with the United States. In both Britain and Canada, several unions compete for members, since their power and income depend on numbers. British unions must cooperate to form a joint negotiating committee to face the government in all hospital labor relations, but they are rivals too, in ideology as well as in recruitment. Within the same hospital, negotiations for different occupations occur at different times, with somewhat different issues, and different bargaining agents. British and Canadian managements have refused to link or index wages and try to settle the amount in each year's bargaining. As a result, wages are lower than those in comparable governmental and private occupations, particularly in Britain. British society and labor relations are permeated by historical memory, the fear of unemployment and the distrust of management, in contrast to the tacit European collaboration between organized labor and organized management. The traditional British pattern remains under NHS, with many hospital workers, low wages, unnecessary overtime in order to raise income, and bonus schemes that raise income without motivating higher productivity. Each hospital now has a separate agreement with workers, it can strive for different wage increases and different rules, and occasional national strikes are called as part of the annual national bargaining. As in other British industries, a strike by one craft over a limited issue can shut down one or many hospitals, since other crafts and truckers may respect the picket line. Hospital unions in Britain are stronger, more militant ideologically, more hostile to management than those in the United States; wildcat strikes are much more common because of anxieties over work rules and layoffs; and therefore hospital labor relations have been more troubled in Britain during the 1970's.<sup>10</sup>

Britain illustrates an organizational problem in relating hospital labor relations and large economic policies. Every government has an incomes policy, at least for its own employees. In negotiating with the unions of civil servants and other public sector workers, it must decide how much to offer and how much to agree to. If it is trying to restrain price and wage inflation in private employment -- either by controls or by exhortation -- the government cannot set a bad example.

In the countries with linking of wages, the government's income policy is implemented in health automatically. Government negotiates with the principal civil service unions in France and Germany, trusted autonomous public tribunals or joint arbitration committees settle deadlocks, and hospital workers automatically get the higher pay rates appropriate to their job ratings. In countries where the hospitals are private, such as Holland, the wages are set by collective bargaining between the hospital association and the unions, in practice they settle on the same annual increases as in other private negotiations, government civil servants are linked to private wage settlements by formulae, and government is bound to go along with the hospital wage settlements -- provided hospital wages have not broken out of this consensus. Because ultimately the rate regulators can disallow claims to cover exorbitant increases, the rules of the game are to keep all wages in rough parity during the negotiations, so that COZ does not face a problem.<sup>11</sup>

Britain's dilemma is that the hospital workers unions do not accept any government wage policy that keeps them in -- as they claim -- a permanently lower status. Government is deemed an adversary, not an unbiased arbitrator between the hospital workers and society, particularly if the government-of-the-day is Conservative.\* Forced to call in impartial and independent commissions to investigate and arbitrate, government repeatedly finds that the commissions follow terms of reference other than the current incomes policies. The results are often very upsetting, but the government-of-the-day cannot reject a commission's findings without a constitutional crisis. Often the commission is co-equal with the Cabinet, having been appointed by the Sovereign; if it has been created by the Cabinet, its terms of reference are to settle a problem that the normal machinery of government could not handle.<sup>12</sup> Dedicated to cutting the government's wage bill, reducing the public sector's share of the national income, and dampening inflation, the Thatcher Government came to office in 1979, only to receive the reports of a commission previously appointed to redress differentials in pay

\*When the pay of doctors is in dispute, they are more likely to disagree with Labour Governments and get more understanding -- and often greater concessions -- from Conservatives.

between the NHS and the private sector. True to its mandate, the Clegg Commission recommended pay increases of up to 25 per cent.<sup>13</sup> The Thatcher Government had to accept and implement the awards, despite the chaotic effects on its national wage policy and on its NHS cash limits.

As the British experience shows, when government itself is a party to labor relations, as owner and funder of the hospitals, it cannot have the final word. A sovereign must be impartial, not a party at interest. The special commissions that write "recommendations" really are arbitrators between government and private interest groups. Their mandates supersede rather than merely implement the policies of the government-of-the-day.

Canada. The Anglo-Saxon style of unstructured industrial relations operates in Britain, despite the national ownership of facilities, despite the Whitley Council machinery, and despite central Treasury financing. Besides tradition and the unions' rivalry, the government finds the fluid situation advantageous.

Canada has Treasury financing but lacks the potential unity from government ownership of hospitals. They remain independent. Therefore, a constant ambiguity is who is in charge on the employers' side of the table, viz., each individual hospital, the provincial hospital association, or the provincial Ministry of Health:

1. Each hospital. All Canadian hospitals evolved out of the North American tradition, viz., at first each hospital management set its pay and hours unilaterally; then in discussions with committees of employees; then with provincial unions representing different categories of workers. Officially, each hospital's contract is still individual, with special details of its own, even if the provincial hospital association takes the lead in negotiating a frame contract. Often unions prefer individual bargaining, getting favorable settlements from the biggest hospitals first.
2. Provincial hospital associations become drawn into negotiations because an experienced staff and a province-wide body must face the province-wide unions and the Ministry of Health. But the associations have often found the task enervating and thankless and some have tried to back away. They lack management authority over the

hospitals, cannot quickly cut deals, cannot force a hospital to conform to a compromise agreement, and are often blamed for conceding too much. They are not assured of wage pass-throughs in the form of automatically higher provincial grants and inadvertently cause all their members to be squeezed if they agree to much higher wage increases than the province will underwrite in its operating grants. (This occurred in Ontario in 1974, teaching the Ontario Hospital Association extreme caution ever since.) In Quebec, the hospital association has insisted it is a voluntary professional society, but a common front was needed to face the province's energetic unions; therefore, the Quebec hospitals created a special common bargaining agent, fully empowered to negotiate province-wide contracts.

3. Ministry of Health. The division that screens hospital budgets invariably avoids being pinned down in advance, by telling the hospitals the allowable wage increase. Often it does not know sufficiently in advance what it will get from Treasury Board. Contracts for different classes of hospital worker expire and are negotiated at different times. If the Ministry told the hospitals the probable wage increase it will get from Treasury Board or the probable wage movements in the country, no hospital will be able to settle for less and many unions will get more. By keeping everyone guessing, governments can restrain wage inflation. By staying out of labor relations, the provincial governments hope to avoid a political quagmire. But the fact that they pay the bills prevents them from standing aloof: the unions became militant during the 1970's, they presumed that the provincial government would rarely risk refusing to pay a wage award for the eternally "underpaid" hospital workers, and the hospital managers gambled (usually correctly) that the provincial governments would underwrite any but the most exorbitant settlement.<sup>14</sup>

A motive for creating a special bargaining committee in Quebec was the need for a compact device that could communicate informally with the provincial government too, before and during the negotiations with the unions.

The methods in Canada change, in some provinces more often than others. For example, Ontario gravitates between individual hospital and province-wide negotiation; the bargaining unit varies among occupations. At times a provincial Ministry makes clear its allowable wage increases -- particularly if it has given the annual global budgets before the time for the labor renewal negotiations -- at other times it leaves unclear the percentage increase that it will underwrite.\* At times a Ministry adds money to the installments of each global budget to cover an individual wage award since the start of the fiscal year; at other times it collects all the settlements and then underwrites a total figure that may or may not cover every award.

#### MEDICAL STAFF STRUCTURE AND CUSTOMS

Issue. The hospital is the doctors' workshop, their activities make it expensive, their new proposals cause sudden jumps in its costs. They hear about new services and new equipment, they press for adopting them, they expect employment of additional nurses and technicians to operate them.

Traditionally doctors in the United States and in other countries have never thought much about organizational fund-raising and costs. They have thought about treating illness in the most effective ways clinically, and they have assumed that the hospital was set up for their convenience. If they needed something, the hospital would supply it, and therefore someone else found the resources. The doctor had discretion to use tests and treatments as he thought best, until the patient recovered; only then would tests and treatments become "unnecessary." Doctors in the United States and elsewhere have thought a great deal about money -- one doesn't become society's highest paid occupation otherwise -- but from the viewpoint of how to accumulate and invest their personal incomes.

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\*A Ministry of Health's deepest secret is the size of the contingency fund it maintains to cover over-runs of individual hospitals at the end of the year and to cover over-ceiling wage agreements that it will reluctantly underwrite.

Nonprofit hospitals have become expensive in the United States because so many senior doctors are involved. Far more fully practicing physicians are affiliated with American than with any foreign hospitals. The American nonprofit traditionally had an open-staff system, with admitting privileges for many local office practitioners. Hospitals now differentiate; many distinguish between active physicians who spend much time in the building, admit many patients, and perform extra chores; "attendings" or "courtesy" physicians spend more of their time in office practice but may still hospitalize and treat patients there. Besides all the activity generated by the seniors, the residents and interns are fully licensed practitioners, often are left with full responsibility, and order many tests.<sup>15</sup>

Nonprofit and proprietary hospitals compete for doctors who do expensive things, not for doctors whose forte is saving money. An American hospital's problem is to fill its beds; the nonprofit must find enough privately insured and self-paying patients to collect charges over costs, to compensate for its losses on other patients; the proprietary needs to cover all its fixed costs and earn profits; every hospital gains prestige by a high level of activity in technically advanced fields. Hospitals install new services and new equipment to attract affiliations from energetic and respected physicians, and to keep them from changing to affiliations elsewhere.<sup>16</sup>

Difficulties. The problem for the hospital director is amortization of any debt incurred to create or to expand the building, to buy the new equipment. If terms were favorable and charges are high enough, the hospital can pay off the debt with limited utilization. If a new facility or new equipment is needed to attract and keep a doctor, it may be effective enough for that purpose even if it is idle most of the time. If the hospital's sponsors or the doctors' friends have donated the building or equipment, it appears to be "free."

The competition among hospitals leads to acquisition of many less used facilities and pieces of equipment. The result is high costs for the system as a whole. If certain paying programs are committed to cost-based reimbursement and if all operating costs of the hospital are included in the calculations -- including facilities and equipment with

high fixed costs and low utilization -- the price for patient-day is high. So, American planners have tried to ration new acquisitions by certificate of need.

America's open-staff hospitals are not only more difficult to administer, but they seem inherently more expensive. The greater the number of senior doctors involved in tests, treatments, and other activities, the higher the costs.<sup>17</sup> In addition, the hospital's house staff and nurses must cope with a great variety of habits in clinical technique, in length of stay, and in costliness.<sup>18</sup>

During the late 1970's and 1980's, American doctors became targets of educational campaigns to make them more cost-conscious, to urge them not to order unnecessary tests and treatments. The AMA appealed with publications and manuals for cost-consciousness sessions in local medical societies.<sup>19</sup> Blue Cross developed its educational literature and motion pictures for doctors.<sup>20</sup> Medical journals ran articles.<sup>21</sup> Hospitals devoted medical staff meetings to cost problems and methods of avoiding waste, showed doctors the patient bills that they had ignored before.<sup>22</sup> These are consciousness-raising efforts, but the cost-raising structures and motives remain in effect. Restraint may be practiced by many hospital doctors for the first time, but a problem is the number who are not involved.<sup>23</sup> To be effective, cost containment must be a program designed to fit the medical staff structure of the American hospital.<sup>24</sup>

Evolution abroad. As in the United States, medical education abroad has trained doctors to think of the best clinical practice, without the cost consequences. Fee-for-service payment is thought to reinforce a presumption to act and to use the more technical methods, as in the United States.

Some organizational competition encourages the installation and use of more technology abroad, as in the United States. For example, when a university medical center persuades a physician to accept a professorship, he lists the new programs, facilities, and personnel it must install. Proprietary hospitals with larger staffs compete for doctors with the largest private practices, and the doctors insist on the latest equipment. The newer and larger proprietary hospitals in France, Germany, and Switzerland depend on such doctors: the owners earn profits only by sharing their fees.

Consciousness-raising programs about costs are sponsored by some European medical associations and are implemented in some hospitals. But they are not very prominent, since the more binding and universal cost containment programs -- viz., rate regulation, budget allocations, and negotiations with sick funds -- are in operation. A motive for the several consciousness-raising appeals in the United States has been to head off enactment of European-type laws with mandatory cost controls.

Several structural characteristics of European hospitals focus the medical staffs' cost-generating pressures. In practice nowadays, the result is restraint, but this is not inevitable. An important contrast with the American hospital is the size and structure of clinical staffs. European and English hospitals have closed staffs, and therefore fewer doctors have admitting and treatment privileges than in the United States. Hospital doctors and office practitioners are distinct. Once, more community doctors could treat patients in hospitals -- never as unlimited as the American attending system -- but this is possible now only in very small hospitals in small towns. (In these cases, only a few doctors do all the ambulatory and inpatient care for the area, and more difficult cases are sent to regional hospitals with closed staffs.) As a result, only a few doctors order tests and treatments, only a few request new equipment.

Most European hospitals are organized more hierarchically than the American. They consist of clinical services, each directed by a chief. Once each service was large (surgery might have had 60 to 200 beds in a large hospital), some services have been divided into sub-specialty services, but many large services still exist. A recent trend is a less monarchical structure: in some countries, a few senior specialists are now appointed in a field -- somewhat like an American "department" -- but one is the most senior and is the management chief. The European counterparts of American interns and residents are more subordinate to the chief, in contrast to the considerable discretion of an American chief resident, because the European chief of service is always present. The chief directs all care, decides purchases of new equipment, and decides about new hirings. Once investment was a free-for-all:

every chief sent proposals to the hospital's governing board and looked for money in the community or among business firms, but no longer.

Investment money became available in many countries after 1960 by outright government grants (as in Germany and Switzerland) or by loans from special public funds (as in France). This has required official applications, the setting of priorities within the hospital, and therefore careful financial scrutiny of each scheme. This has required a cohesive medical staff organization to write a priority list. I described the procedure in Chapter XII, pp. 19-21, supra. In short, each service chief develops a proposal for new equipment or for new construction, either at any time or in response to an annual notice from the lay director; using prescribed forms or informal papers, the service chief and the hospital's finance officer prepare a detailed summary and an estimate of the costs; the entire senior medical staff in plenary session or the governing committee of service chiefs discusses the merits and need of the proposal and lists them by priority; if the money is fixed by the government grant or by the hospital's borrowing capacity, the medical staff sends the hospital's governing board only a short list within that total; the governing board sends the serious proposals (including contingencies) to the grantor or lender.

This procedure has made the service chiefs much more knowledgeable about the costs of acquiring new programs and new equipment. They must think about each other's disciplines, too, because of the hospital-wide prioritizing. In practice in many hospitals, each chief is allowed a certain investment total each year, and he must think about tradeoffs, viz., whether several smaller items will benefit his program more than certain expensive ones. The procedure could make the chief sensitive to long-term operating costs from each scheme, but only a few grantors, lenders, or planning agencies (such as several Swiss cantonal governments) require the applications for the new acquisition to estimate future results.

The chief is someone the lay director and financial officer can talk to about operational budgeting and about controlling operating costs. If the country's hospitals have cost-center accounting by clinical service -- as in Switzerland and France -- the service chief

can participate in designing a prospective budget at the start of the year, can monitor its implementation from monthly and quarterly computer reports, and can review final results at meetings. Once service chiefs competed over growth in work, equipment, and staffing; but I encountered some Swiss hospitals where keeping within one's budget was admired. More of the chiefs now get full-time salaries, less of their income derives from fee-for-service and private practice.

The structure of chiefs and medical staff committees can become a peer group on behalf of efficiency and restraint. But this is not automatic: the group could join in pressing the governing board and the government for expansion. Much depends on leadership, viz., the viewpoint of the chairman of the medical staff committee, the viewpoint of the senior chiefs, and their respect for the lay director. European medical staffs lack formal devices for peer control, such as American tissue committees and PSRO's; these may boomerang by arousing suspicions and lead to tacit agreements to leave everyone alone.

The alternative to a structure with strong chiefs is a free-for-all. That is expensive, because each doctor pursues his own interest in traditional ways. There is no one the lay director can enlist to persuade the rest of the medical staff to economize. Examples are The Netherlands and Great Britain. Dutch specialists have motives and opportunities to have higher utilization with more expensive methods: they incur large debts when acquiring their hospital posts and must pay them off; in a few hospitals, they still follow an older practice of personally hiring some junior doctors and paying the salaries from their own practices; they are paid entirely by fee-for-service both under official NHI and private insurance; they can easily persuade the hospital to self-finance new equipment and pay it off in the daily charge. The senior doctors (although called "chiefs") do not assume the organizational responsibility for services in the hospital like other European chiefs. They do not scrutinize each other's work and certainly do not deplore each other's earnings. One result has been that hospitals have risen more rapidly in costs in Holland than anywhere else in Europe.

Britain's medical staff structure is also egalitarian and rudimentary, but the potential cost-raising consequences are prevented

by the financial structure of the National Health Service. Within the hospital, the specialists are not responsible for managing clinical services. While officials grumble that they order too many tests and use too many supplies, the doctors cannot arrange acquisition of expensive new equipment and cannot run up operating costs. British vertical budgeting dictates new investment and limits annual growth in operating costs. The hospital doctors cannot become rich by headlong utilization; they are paid salaries.

#### PAYING THE HOSPITAL DOCTOR

Issue. The United States has many arrangements for paying hospital doctors, just as it abjures standardization in many other topics. The open-staff systems have been common, with office doctors visiting briefly to see their regular patients. There has been a steady increase in the numbers of hospital doctors based entirely or primarily in the hospital, and a few hospitals have had closed staffs.

The attending physicians and many hospital-based doctors have been paid by fee-for-service, where the fees are decided by the doctors themselves. Prospective reimbursement by fee schedules -- whether negotiated or mandated -- has been unusual. Some hospital doctors have earned salaries: in the past, the many junior doctors were paid small salaries, but recently they have gotten more; as more senior doctors become full-time, more get large full-time salaries. Once before salaries became common for senior doctors, a problem was how to pay the full-time radiologists, pathologists, and anesthesiologists; a simple method was a percentage of the gross revenue of their departments, where they worked in lieu of an office outside. Percentage-of-receipts has rapidly been replaced by fee-for-service (for radiologists and anesthesiologists) and salary (for pathologists), in large part because Medicare insists on separating payments for the hospitals and doctors.<sup>25</sup>

Almost no hospitals are paid all-inclusive charges in the United States. Separate bills are sent by the hospital and by the doctor. Implementing the distinction has been difficult in teaching hospitals: they have full-time salaried junior and senior physicians for teaching,

research, and patient care; their geographic full-timers can also collect fees; the hospital's billing office includes the doctors' salaries in the daily charges but also serves as the doctors' collection agency for the fees. Blue Cross has tried to avoid double-billing for physicians' care and has tried to avoid sharing in teaching costs by refusing to include much of the salary costs in the daily rates. But the Medicare law does not allow the national government to refuse so flatly. Medicare Part A has paid hospitals (including the salaries), Medicare Part B has paid the fees, and there has been unending dispute over whether the government is paying some doctors twice for the same clinical acts or has been paying the hospital for patient services by senior doctors that they do not personally perform.

Difficulties. Some critics have long complained that fee-for-service increases dangers to patients and increases the costs of medical care by motivating doctors to perform unnecessary work. Such effects occur both in the office and in the hospital, but they are particularly dangerous in the hospital, because they involve unnecessary surgery. Salaries would lead to stable commitment to the hospital and treatments appropriate to the patient's need.<sup>26</sup>

Percentage-of-receipts is particularly criticized. The doctors are said to use certain departments of the hospital as money factories for themselves; the greater the number of tests and treatments, regardless of need, the greater their income. The hospital cannot control those departments.

The possibility of earning many high fees through hospital practice is said to motivate the doctors to press for elaborate and expensive equipment everywhere. Instrument companies spring up to mass-produce it. If the hospitals share in the revenue, all the directors help buy it.

Although the physician generates hospital costs and earns his living from the hospital, the laws and payment methods treat him as an "outsider." Regulators and third parties are not allowed to use their controls over the hospital's budgets and rates to restrain the remuneration of the doctor, unless he has voluntarily agreed to be its salaried employee.<sup>27</sup>

The loophole enables the hospital to evade regulatory and fiscal controls by contracting with their physicians. For example, if it seems unlikely that the HSA and SHPDA will grant a CON for new equipment in radiology, and if the state regulators and third parties will not allow the hospital to include the costs of leasing and using the equipment, several of its physicians (particularly radiologists or pathologists) incorporate, rent the equipment, and sell their corporation's services to the hospital. The doctors are then under heavy pressure to use the equipment to the maximum, to cover the equipment rental, the space rental, and the operating costs. The system as a whole probably spends more.

Evolution abroad. Traditionally, all European countries have distinguished between the qualified specialist and all other doctors. As credentials and organizations became more structured during the twentieth century, intramural practice within hospitals became separated from office practice. Only specialists had appointments in the hospitals. All general practitioners and some specialists were based in private offices. Some specialists in private practice treated patients in "private clinics," which were half-way between offices and full-scale hospitals.

Office doctors still see their patients in the small public and nonprofit hospitals in the small towns. These hospitals lack the size and finances to employ their exclusive medical staffs. Most patients are elderly; the clinical problems are simple, and the demanding cases are referred to more advanced hospitals further away. The larger the hospital, the greater the number and complexity of cases in each specialty, and the more likely the medical staff is full-time intramural. Middle-sized hospitals in some countries may not have enough work in certain specialties for a full-time intramural chief of service; examples are orthopedics, ophthalmology, and ENT. So, if a specialist exists in office practice in the town, he is given a contract to practice part-time in the hospital; in France, he receives a part-time salary; in Germany, he collects fees, while all other hospital doctors are salaried.

Following is the distribution of the medical profession in West Germany in 1978.<sup>28</sup>

|  | <u>Number</u> | <u>Proportions</u> |
|--|---------------|--------------------|
| Full-time in hospitals   |               |                    |
| Chiefs of service  | 9,176         | 7.0%               |
| Juniors  | 50,388        | 38.6               |
| Office doctors with part-time hospital appointments (Belegärzte) | 6,061         | 4.6                |
| Office doctors   |               |                    |
| Specialists  | 25,407        | 19.5               |
| General practice   | 27,568        | 21.1               |
| Administration and research                                      | <u>11,814</u> | <u>9.1</u>         |
| Total  | 130,414       | 100.0%             |

In every country, laws, customs, and the standardization of finance under national health insurance standardizes the methods of paying hospital doctors. Once all chiefs received part-time salaries and accumulated the rest of their incomes from private practice or from NHI practice under fee-for-service either within the hospital ("geographical full-time" in American terminology) or in private clinics outside. The junior doctors have always been full-time and salaried, with very low pay in the past. The trend has been higher salaries for all ranks and commitment of more hours by the senior doctors. Now in most European developed countries, most chiefs of service are full-time salaried. In a few countries, such as Germany, the chiefs have rights to see private patients, hospitalize them in the hospital's private rooms, and collect fees. Their fees come in cash or from private health insurance, not from the sick funds under NHI.

To be a salaried worker in a government agency implies membership in the civil service. Both the senior and junior doctors in French German and Swiss public hospitals are satisfied to become civil servants, since many other respected persons occupy this status, such as the university professors. But in some countries, the senior hospital doctors try to preserve an image of autonomy and consider themselves above the ordinary civil servant; for example, the salaried consultants in British hospitals have a special status, with contracts from the Regional Health Authorities.

Current methods abroad. As the medical staffs have become more integrated into the organization and budgets of the hospitals, paying them has become a simple part of paying the hospitals generally. The salary rates for all junior doctors and the basic rates for the chiefs of service are identical with or close to the salary scales for civil servants. The medical association periodically negotiates the correspondence between ranks in the medical staff and ranks in the general civil service wage scales; and the union of salaried civil servants gets a new overall wage level for all ranks each year.<sup>29</sup> The nonprofit hospitals usually agree to a similar salary structure for doctors and all other employees, after negotiations between representatives of the hospitals (sometimes a national or provincial association of private hospitals) and representatives of the workers (including the medical association). In some countries, chiefs of service can obtain special contracts and special salaries. This is particularly common in the teaching hospitals

The salaries of the doctors and of all other hospital workers are mixed into the total costs for calculation of the hospital's daily charge or global budget. In the nonprofit and public hospitals of most developed countries, there is no separate calculation of a patient's medical costs, no separate billing of his medical fee. The patient is treated by the entire medical staff, and not by the chief of service alone. For simplicity in calculating the daily charge, it is assumed that every patient uses a share of physicians' services proportionate to his length of stay -- i.e., all physicians' salaries are an element in the daily charge, spread equally across every daily charge.\* If the sick

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\*This is generally true of countries with daily charges and salaried physicians. In the intricate subject of hospital finance, some qualifications occur in every country. France retains a vestige of the days when hospital daily charges did not include the payment of doctors, and the physicians collected fees instead of salaries. The hospital now pays them salaries but collects some of its revenue from the sick funds by sending bills specifying individual services performed by the entire medical staff for each patient. Therefore, the sick funds pay each hospital a nearly all-inclusive daily charge plus a few fees for medical services. The money goes into the hospital's accounts to help pay the medical staff's salaries. This is a bookkeeping procedure that gives the hospital additional work but yields little benefit in recording, since the medical acts are specified on the bills in broad categories but not in detail.<sup>30</sup>

funds pay both hospital costs and medical charges, administrative trouble is saved by pooling and averaging them. By getting a salary, the doctor can predict his income.

Fee-for-service billing is used when the patient has a personal physician -- primarily in ambulatory care. But he has no personal physician in the hospital unless he retains the chief privately. Since the proprietary hospital is an extension of private office practice, the patient is treated by a personal physician and not by a collective medical staff. The proprietaries lack house staffs but merely have duty officers at night, on weekends, and in the emergency room. Therefore the proprietaries in Europe bill the patient or his carrier a less inclusive daily charge for hospital care, and the doctor bills directly for his fee, often according to a fee schedule for private insurance.

Germany does not have a single national pattern, because some senior hospital doctors are office-based (the Belegärzte) and because the sick funds do not pay the office doctors by the same route as they pay the hospitals. When the patient occupies a service with a full-time salaried chief of service, the patient is covered by an all-inclusive daily charge based on the total pool of all doctors' salaries (a grosse Pflegesatz). But if he has been treated by a Belegarzt he is covered by a daily charge that is slightly lower, reduced by the average cost for a chief in that service (a kleine Pflegesatz). The Belegarzt sends bills for his care for that patient according to the fee schedule for medical care; he mixes that patient's bill in with all others from his office practice. Each sick fund pays the hospital directly all the daily charges (i.e., all the grossen Plegesätze and all the kleinen Pflegesätze). The Belegarzt sends all his bills to the provincial association of insurance doctors (the Kassenärztliche Vereinigung or KV), which pays him and recovers the money from the sick fund. Avoiding this extra administrative effort is the purpose of the system of salaries and all-inclusive daily charges.

Do salaries generate less self-interested and less unnecessary clinical work than fee-for-service? Virtually no research has ever been

done about the work of hospital doctors abroad, and one cannot answer.\*

Hardly any statistics can be inferred from hospital records for such comparisons; a purpose of salaried payment is to eliminate detailed economic records about work. Germany is one of the few countries where salaried and fee-for-service payments are used for the same hospital work -- i.e., a comparison of the salaried chiefs, the Belegärzte, and private hospital doctors -- but no detailed data exist to compare them, and the KV's would not cooperate with any research testing a hypothesis that fee-for-service motivates too many treatments.

In the countries where the doctors in proprietary hospitals collect fees for laboratory tests, both the hospital organization (i.e., the doctor-owner) and the pathologist may be motivated to order many tests. The tests are paid for under the fee schedules negotiated between the medical association and sick funds to pay the individual doctor. But the pathologist usually works in a proprietary hospital or medical group, and he personally or his organization can buy an autoanalyzer. During the 1970's, the number of tests skyrocketed all over Europe.<sup>32</sup>

An important reason for much testing is curiosity -- about the patient and about the equipment. Curiosity is official policy in the teaching hospitals of Europe and Canada, and the large number of tests is one reason they are more expensive than nonteaching hospitals, as I said on p. XI-14, supra. The tests are not personally profitable to the doctors, since all the professors, chiefs of service, and juniors are full-time salaried. In some countries, the chiefs in nonteaching hospitals have private practice rights and might profit indirectly from trying out new tests and treatments under the hospital's normal NHI business, since they might find the knowledge useful in their private practices.

No country except the United States and Canada has ever had percentage-of-receipts payment for any hospital doctors. Radiologists and pathologists abroad have been paid like other hospital doctors: in

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\*In theory, flat-rate methods like salary should motivate fewer services than fee-for-service, but one needs evidence of the results and not assume a hypothesis to be true. Other incentives may operate simultaneously, and everything depends on the influence of the hospital organization and local clinical custom. One research project in the United States found that salaried Veterans Administration physicians worked more expensively than other hospital doctors paid by fee-for-service.<sup>31</sup>

the past, a combination of small part-time salaries and fee-for-service; recently a trend toward full-time salaries; physicians in proprietary hospitals bill by fee-for-service, as if they are in office practice. However, radiologists and pathologists become steadily more productive with the help of new equipment and technicians, and their incomes at times have risen faster than the clinicians. In this respect, fee-for-service works like percentage-of-receipts. The American national government has struggled to restrain Medicare payments to the radiologists and pathologists,\* and the similar effort in foreign NHI has involved the medical associations. They negotiate the relative values in the fee schedule, and they fear that the radiologists and pathologists will get too much of the sick funds' limited cash, leaving less to the clinical specialties. So, the committees representing all the specialties occasionally pressure the radiologists and pathologists to agree to lower relative values in the medical associations' bargaining proposals.<sup>34</sup>

The European hospital has become steadily more structured, involving the medical staff in the organization's economic decisions (described earlier in this chapter), and including the senior physicians' pay in the hospital's budgets and rates (described in previous pages). As in many other areas of health services, the Anglo-Saxon countries tried to retain their less structured arrangements. Even now, the hospitals of Great Britain and Canada lack a strong service setup in their medical staff. However, they had to institute prospective reimbursement of hospital physicians' pay, necessarily determined independently of the hospital global budgeting. British consultants and the junior hospital doctors have their salaries fixed annually by the Review Body, and their paychecks come from the offices of the health authorities. Canadian hospital doctors are paid according to the fee schedule negotiated

\*American critics have always assumed that percentage-of-receipts is the strongest possible incentive to the venal multiplication of work, and therefore Medicare and Medicaid have been used as a lever to abolish it. But the full story may reflect an important lesson: a single pecuniary incentive may operate differently from the prediction, depending on organizational circumstances. Payment by percentage-of-receipts implies that the physician is an integral part of the organization and is fully responsible for a compact department. He might generate less work and lower costs than a congeries of individual attendings who use an open facility and are paid by fee-for service.<sup>33</sup>

annually (or less often) between the provincial Ministry of Health and the provincial medical association, and their item-of-service payments come from the office that administers Medicare (rather than hospital) payments. The average American hospital doctor is subject to no such standardization and (unless he accepts assignment under Medicare and under Blue Shield's UCR) no prospectivity.

#### LESSONS FOR THE UNITED STATES

Workers and their wages. Fighting unions can keep them out of hospitals, particularly in countries with weak labor movements. Keeping them out can save wages. But this approach may be more expensive in some ways. Much tension and trouble can result. Personnel turnover and dropouts from health careers may increase.

Even if a country's unions have low membership, it may be public policy to recognize them as a bargaining partner. Legitimate and binding agreements may require some spokesmen for workers.

Unions oppose collective bargaining with several hospitals if they can divide and conquer. In the absence of unions, hospitals are rivals, each trying to lower its own labor costs, each settling its labor relations independently. But if a resourceful union is active in the region, the hospitals may join in bargaining with it.

Unions may ultimately favor nation-wide or province-wide settlements from the hospitals and commit government to support them. The hospitals may go along with such arrangements, in order to use the office of the hospital association to maximum advantage as bargaining agent and in order to pressure government into passing-through the wage settlement.

Deciding budget, rates, and wages within each hospital increases the power of the manager. He can coordinate wage settlements with rate determination. Linking of wages and collective bargaining on a wider scale reduce his discretion and power. They make his life simpler and calmer.

If decisions are made about wages and rates outside the hospital, on a regional or national scale, problems arise in coordinating them. In a situation without rate regulators and third parties, each hospital

could adjust them freely, but in practice some constraints occur. So, the hospital may have to be in periodic contact with the regulators and third parties to learn the wage increases they will accept and then to obtain the rate adjustment. Wider collective bargaining by the hospital association and linking are designed to simplify the decisions and get across-the-board pass-throughs for all hospitals. Then the regulators and third parties won't have the arduous and conflictual task of second-guessing the wage awards of each one.

Rate determination by fiscal years and third-party rate increases by fiscal years create a demand to schedule all labor contracts in the same way. But, if labor is organized on a craft basis, the unions resist.

Wage pass-throughs are usually adopted by regulators if wages are linked, if national or provincial contract bargaining occurs, and if government tacitly or openly is involved in the labor negotiations. But government usually tries to avoid getting pinned down, lest union negotiators maneuver to get even more money, lest Treasury grant less. If regulators or government grantors can hedge over whether they will pass wage awards through, the hospital association will be a stricter bargainer and all sides will maintain parity with other private sector wage settlements.

A regulatory agency or a government budget-granting system are needed if wage awards for hospitals are regularly coordinated with national economic policy. These agencies can then implement guidelines from the economic policy offices on wages as well as on other price matters.

In a payment system where government grants the hospital operating budgets, responsibility is always unclear. Should the unions bargain with hospitals or with the government? How should deadlocks be settled?

The United States now staffs its hospitals lavishly because wages are low, rate regulation is weak, and hospital managers have a free hand in allocating personnel. If unions become stronger and wages rise, American hospitals might become more economical in the use of labor. Having become adjusted to lavish staffing levels, a problem is whether the hospital can press workers to speed up.

Doctors. Attempts to find purely financial incentives for doctors to economize are a mirage. Doctors' training and professional rewards induce them to increase services, work in more complex ways, and spend more. Re-educating and exhorting them will be helpful only in a fully supportive organizational setting, with appropriate professional rewards.

The trend in the world is more structure in the hospital, involving the medical staff collectively in its financial constraints and financial decisions. The entire medical staff learns about priorities and tradeoffs, about the practical consequences of clinical aspirations. Regulators, grantors, and third parties thus can finally deal with the principal authors of mounting costs. Medical practice might then become more efficient.

One shouldn't leap from incentives-in-theory to behavior-in-practice. A payment method does not always work out in exact results as predicted. Every payment method is part of a total organizational setting, and many incentives and influences operate together.

For example, salaries do not automatically generate less work and lower costs than fee-for-service. Salaries are associated with employment in an organized hierarchy, and the system can press physicians to do more work rather than less. The system may or may not make them aware of practice costs.

Very little research has been done comparing the effects of salaries and fee-for-service.

## FOOTNOTES

1. An overview of the hospitals' hostility toward unions and their success in limiting unionization is in Thomas A. Barocci, Non-Profit Hospitals (Boston: Auburn House Publishing Company, 1981). See the remarkable tone of the remarks at a special meeting of the American Society for Nursing Service Administrators, "Improving Communication with Nurses Seen as Key Way to Deter Unionization," Hospitals, Volume 55, Number 3 (1 February 1981), pp. 21, 23; and the viewpoint throughout William J. Emanuel, "Nurse Unionization is Dominant Theme," Hospitals, Volume 55, Number 7 (1 April 1981), pp. 121-128.

2. Cedars-Sinai Medical Center and Cedars-Sinai Housestaff Association, 223 NLRB No. 57 (1976). A dissenting opinion protested that the Board has decided differently in other industries recognizing bargaining units for students who are also employees, rendering services and receiving pay from their organizations.

3. A convenient short history of organized labor relations in American hospitals is Richard U. Miller et al., The Impact of Collective Bargaining on Hospitals (New York: Praeger Publishers, 1979), Chs. 2-5. Overviews of the present situation are Roger Feldman et al., Hospital Employees' Wages and Labor Union Organization (Washington: report to the National Center for Health Services Research, 1980), Ch. I; and Impact of the 1974 Health Care Amendments to the NLRA on Collective Bargaining in the Health Care Industry (Washington: U.S. Department of Labor and Federal Mediation and Conciliation Service, 1979), Chs. 3, 4, and 8.

4. Frank Sloan and Bruce Steinwald, Hospital Labor Markets (Lexington, Mass.: Lexington Books, 1980), *passim*; and Feldman, op. cit. (footnote 3, supra), Chs. II and III.

5. Barocci, Non-Profit Hospitals (op. cit., footnote 1, supra), pp. 123-130. Comparative earnings data for recent years are published frequently in HCFA's periodical, Health Care Financing Trends.

6. My calculations from Hospital Statistics: 1980 Edition (Chicago: American Hospital Association, 1980), Table 1. The foreign

data appear in the national monographs that accompany this volume. The unusual American trend was noticed in Martin Feldstein and Amy Taylor, The Rapid Rise of Hospital Costs (Washington: Council on Wage and Price Stability, 1977), pp. 13-19.

7. To a European, an American hospital union uses up much of its energy in obtaining and keeping recognition. Nick Bosanquet, "Unions and Hospitals: The American Case," British Medical Journal, 15 March 1980, pp. 806-807.

8. Whether American hospital workers are "lower," "higher," or "equal to" other workers' wages therefore depends on time, area, and comparison groups. See the contradictory results in Victor R. Fuchs, "The Earnings of Allied Health Personnel," Explorations in Economic Research, Volume 3, Number 3 (Summer 1976), pp. 408-432; and Sloan, Hospital Labor Markets (op. cit., footnote 4, supra), pp. 76-78.

9. For details on European hospital wage determination, see Glaser, Paying the Hospital in France, Ch. VII, pp. 17-26; and Donald White, Pay Negotiations in Six Overseas Health Services (London: Personnel Division, Department of Health and Social Security, 1980).

10. Glaser, Paying the Hospital in England, Ch. IX.

11. H. ter Herde, "Het COZ," in Guus Schrijvers (editor), Management in de Klinische Gezondheidszorg (Lochem: Uitgeversmaatschappij de Tijdstroom, 1979), p. 77. Ter Herde describes an earlier period, when COZ passively accepted higher wage awards that seemed to exceed private wage trends. This was a period -- experienced by all countries -- when hospital wages caught up with the outside rates. Since then, COZ and the hospital association have stiffened.

12. The Labour Government lost a showdown with the Review Body on Doctors' and Dentists' Remuneration in 1970. Glaser, Health Insurance Bargaining (New York: Gardner Press and John Wiley, 1978), pp. 171-173.

13. Standing Commission on Pay Comparability (Hugh A. Clegg et al.) (London: H. M. Stationery Office, 1979 and 1980), four volumes.

14. The system made the hospital managers weak bargainers, wages rose quickly during the 1960's and early 1970's, and hospital costs exploded, according to Robert G. Evans, "Beyond the Medical Marketplace,"

in Richard N. Rosett (editor), The Role of Health Insurance in the Health Services Sector (New York: Neale Watson Academic Publications and National Bureau of Economic Research, 1976), pp. 447-462. Ontario's attempt to lid hospital costs after 1969 were foiled by the militance of the unions, according to John J. Deutsch et al., Report of the Minister of Health's Committee to Examine the Effect of Fiscal Constraints on Hospital Employees (Toronto: Ministry of Health, Province of Ontario, 1974).

15. A thorough study of the American medical staff structures and the internal affairs of hospitals is Milton Roemer and Jay W. Friedman, Doctors in Hospitals: Medical Staff Organization and Hospital Performance (Baltimore: The Johns Hopkins Press, 1971). A comparison with Europe's and Britain's closed staffs is in Glaser, "American and Foreign Hospitals," in Eliot Freidson (editor), The Hospital in Modern Society (New York: The Free Press, 1963), pp. 37-72.

16. For example, in the proposal by a Maryland hospital for a rate increase to cover the cost of additional staff, summarized in Harold A. Cohen, "Rate-Setting and Competition: Are They Compatible?" (Baltimore: Health Services Cost Review Commission, 1980), pp. 7-8 and 12.

17. Mark Pauly, "Medical-Staff Characteristics and Hospital Costs," Journal of Human Resources, Volume XIII (Supplement 1978); and Roemer and Friedman, Doctors in Hospitals (op. cit., footnote 15, supra), pp. 288-290.

18. The great variation in practice habits by American doctors has been documented in several research projects by Steven A. Schroeder, summarized in his "Variations in Physician Practice Patterns: A Review of Medical Cost Implications," in Edward J. Carels et al. (editors), The Physician and Cost Control (Cambridge: Oelgeschlager, Gunn and Hain, 1980), pp. 23-50.

19. For example, Cost Containment Kit for Medical Societies (Chicago: American Medical Association, 1979). Primarily oriented toward ambulatory practice, much of the message applied to hospital practice too. AMA joined the two hospital associations and the associations of insurance carriers in the Voluntary Effort to Contain Health Care Costs, exhorting all providers.

20. Cost Awareness Kit (Chicago: Blue Cross Association and Blue Shield Association, 1979).
21. For example, in the Journal of the American Medical Association, 239: 1629-1630 (April 1978) and 241:1606-1609 (April 1979); The New England Journal of Medicine, 299:76-80 (July 1978).
22. Deal C. Brooks, "A Sampling of Medical Staff Cost Containment Projects," The Hospital Medical Staff, Volume 9 (May 1980), pp. 23-27. An example of a syllabus is Robert A. Armistead and Paul B. Hofmann, "Involving the Physician in Cost Containment," Hospital Financial Management, January 1981, pp. 52-56.
23. Evaluations of these efforts are summarized in Lois P. Myers and Steven A. Schroeder, "Physician Use of Services for The Hospitalized Patient: A Review, with Implications for Cost Containment," Milbank Memorial Fund Quarterly: Health and Society, Volume 59, Number 4 (Summer 1981), pp. 481-507.
24. Richard B. Saltman and David W. Young, "The Hospital Power Equilibrium: An Alternative View of the Cost Containment Dilemma," Journal of Health Politics, Policy and Law, Volume 6, Number 3 (Fall 1981), pp. 391-418; and Jeffrey E. Harris, "The Internal Organization of Hospitals: Some Economic Implications," The Bell Journal of Economics, Volume 8, Number 2 (Autumn 1977), pp. 467-482.
25. Bruce Steinwald, "Hospital-based Physicians: Current Issues and Descriptive Evidence," Health Care Financing Review, Volume 2, Number 1 (Summer 1980), pp. 63-75.
26. Roemer, Doctors in Hospitals (op. cit., footnote 15, supra); and George Crile, "How to Keep Down the Risk and Cost of Surgery," Inquiry, Volume XVIII, Number 2 (Summer 1981), p. 100.
27. Relations between hospitals and the hospital-based physicians are described in David Pieroni (editor), Physician Compensation (Germantown, Md.: Aspen Systems Corporation, 1978). An example of a regulatory commission's inability to include nonsalaried physicians' remuneration within its jurisdiction over hospital costs is the decision in Health Services Cost Review Commission v. Holy Cross Hospital of Silver Spring Inc. et al., Court of Appeals of Maryland Number 43, September Term 1980, Filed 23 April 1981.

28. My calculations from Bundesminister für Jugend, Familie und Gesundheit, Daten des Gesundheitswesens (Stuttgart: Verlag W. Kohlhammer, 1980), pp. 213 and 248.
29. For example, Glaser, Paying the Hospital in France, Ch. VII, pp. 7-15.
30. Ibid., Ch. VII, pp. 1-7.
31. Steven R. Eastaugh, "Cost of Elective Surgery and Utilization of Ancillary Services in Teaching Hospitals," Health Services Research, Volume 14, Number 4 (Winter 1979), pp. 290-308.
32. Theo de Vries, Het klinisch-chemisch laboratorium in economisch perspectief (Leiden: H. E. Stenfert Kroese, 1974), Chs. 3 and 4.
33. Unexpected evidence in Frank A. Sloan and Edward R. Becker, "Internal Organization of Hospitals and Hospital Costs," Inquiry, Volume 18 (Fall 1981), pp. 231-236.
34. Glaser, Paying the Doctor (Baltimore: The Johns Hopkins Press, 1970), pp. 45 and 150; and Glaser, Health Insurance Bargaining (New York: Gardner Press and John Wiley, 1978), p. 101.



## CHAPTER XIV

### MANAGEMENT

How any organization operates depends on the goals and behavior styles of its managers. An organization pursues several aims, and it depends on what those aims are. While the hospital receives and spends money, the goals of the hospital are not primarily the maximization of income. Therefore the question is what the leading managers of the hospitals are trying to accomplish.

### THE AMERICAN SITUATION

Scope. The American hospital has usually been autonomous, and each is separate. In the past and present, the managers and medical staff have been oriented toward that hospital alone, and not toward any larger entity. Chains and multihospital groups have existed, but not widely.

Some of the chains are self-centered in outlook, particularly the proprietaries. The headquarters behaves parochially, using the units to pursue its own aims.

An important exception has been some religious hospitals with close ties to religious orders or religious associations. Their managers may think of themselves and their organizations as servants of a larger religious and human community, extending throughout the country.

Certain environmental features foster an insular perspective within the hospital's management. Several or many hospitals exist in many communities, and each manager must think about survival and growth, about how to beat out the others in market share. Some -- not all -- managers respond by thinking like businessmen, expanding and keeping market shares for their own enterprises. Entering health services research after 1965 and observing some hospital managers, American economists quickly imputed to the entire field the model of the "firm," oriented toward its own survival and growth.

Goals. Leading workers in American health services have always had a mixture of motives, varying by occupation, time, and organization. Once, in America -- but not as extensively as in Europe -- some hospitals were owned by religious orders or by voluntary associations of laymen affiliated with religious sects. Some directors were priests, ministers, or nuns; some were retired businessmen who were active laymen in the religious association.

The atmosphere stressed self-sacrifice: either in religious tradition or in the Nightingale lay tradition, the nurses and domestics were married and devoted, worked long hours, were paid in large part with free room and board, received little pocket money. Hospitals had modest facilities, low prices, and little income. Charitable fund-raising campaigns were incessant.

The physician was always an anomaly in this environment, a participant in the organization but also an outsider, donating time in the hospital but also running his small business from his office outside, treating some patients for free and others for private payment, prospering while most of the hospital staff was sacrificing. Enough restraints existed upon medical incomes, so that the hospital staffs and public thought they were what doctors "deserved" because of their education, skill and responsibility. Until the 1950's, individual medical fees per act were low, the number of services per patient were low, doctors worked exceptionally long hours, the many GP's earned only ordinary upper-middle-class incomes, and the few specialists did not seem excessively paid.<sup>1</sup>

Money engulfed the American hospital after 1960, its management and labor force changed to deal with it, and the new generation of managers were preoccupied with money as a full-time assignment. After 1960, nonprofit and private health insurance, public subsidies for the aged and poor, and public grants for construction spread throughout the country. They were not accompanied at first by effective cost controls; hospitals and doctors had great freedom in setting rates, in proliferating services, and in increasing gross and net incomes.

The hospital secretary and his bookkeeper rose to become the hospital director and the finance manager, superseding the priests, physician-directors, and gifted amateurs. They were often trained in

business curricula, whose ideology was money-making and whose other alumni became successful businessmen. The new hospital managers applied to their organizations the same strategies of growth. Since they managed nonprofit organizations paid in large part by cost reimbursers, their financial strategy was to maximize costs instead of controlling costs and maximizing profits; but they managed financial operations that were as large and even more complicated than those of their peer group directing other service industries. The successful hospital manager and his finance officer expected the same rewards available to successful managers in other fields, such as over \$100,000 annual salaries, free apartments, limousines, expense accounts while travelling, etc.

Meanwhile, the governing boards of American nonprofit hospitals had changed somewhat. Still drawn from the business and professional elite, they possessed the new financial skills that American business was assimilating. They were delighted that the hospital was no longer a millstone, constantly pressing them to pass the hat, but that it increasingly operated like a normal business, pricing its services to cover its costs, spending money on equipment, labor, and materials in order to earn new money, shuffling cost-assignment and charges in order to maximize income from its diverse customers. Unable to understand the increasingly esoteric work of the doctors, the boards became close to the lay directors and financial managers who spoke their language. They were happy to bestow appropriate salaries and perks on executives who could make such complicated and troublesome organizations prosper.

Since economists study money-making and efficient spending in other businesses, when they began to examine the American hospital they easily projected into this new financial maelstrom the same imputations about the motives of the managers and doctors, the assumption that pecuniary incentives would influence them in the ways deemed normal in other economic sectors

#### DIFFICULTIES

The new American managers share with the doctors an interest in the growth -- in technical complexity if not in scale -- of each

individual hospital. They oppose public planning, which limits their growth and functions according to someone else's judgments. They wish free hands for themselves. But without planning and regulation, many organizations have expensive equipment used part of the time, instead of fewer organizations using fewer items more of the time. Appeals to economize voluntarily are little heeded, since the managers gain credit by giving the doctors what they want, gain less prestige themselves if their organizations make do with older equipment and more crowded beds.

With every organization trying to grow and spend, the system as a whole becomes very expensive. Sick funds and taxpayers are burdened. Many hospitals cannot keep up with the competitive pressure (and the doctors' demands) for new equipment, frequent replacements, and more <sup>2</sup> credentialled technicians.

Government and the hospital associations exhort the director to be economical, to try to restrain the doctors' appetite for supplies and equipment, to try to keep annual increases in costs close to the general inflation rate. But, except in the brief period when good behavior was needed to head off the Carter Administration's statutory controls, the Voluntary Effort falls short. The director remains subject to all the pressures from within the organization to expand its work and make its services more elaborate.

If the ethic of the hospital director is only to obtain the maximum resources for his own organization, he has no inhibitions about manipulating the payment rules to get more money from sick funds and patients, contrary to the intent of regulations and of negotiated agreements. The cynical maneuvers between hospital managers on the one hand and regulators and third parties on the other hand -- so foreign to the traditions of religious charities -- were described in Chapter IX, supra. If their goal in life is to earn the greatest income for themselves in the "health industry," the managers readily transfer from hospital directorships into directorships of corporations (such as drugs) that pay much more money and perquisites for less harassed work.<sup>3</sup>

The motives of hospital managers are quite varied of course. Many retain some of the religious and humanitarian impulses that dominated their predecessors and that may have motivated their original

choice of a health career, despite the financial and secular aspirations that have become so salient. To a great degree, hospital management shares the style of American management-in-general, characterized by oversight through financial reports, evaluating subordinates' performance from the "bottom line" of the balance sheet, staying in the office instead of making the rounds of the plant, letting the technical specialists learn about the technology. This is not a good model for leading a hospital, since it has had serious effects on American industry, such as a declining understanding by the managers about their companies' technology and products, pressure to maximize cash balances at the expense of long-term viability, a search for unproductive but apparently profitable uses of funds (such as mergers and tax shelters), a declining personal identification with the firm and the product, a tendency to loot the company for income and personal expenses.<sup>4</sup>

Since the hospital managers and doctors set the modern example of shorter hours and higher pay, the lower ranks join. The religious commitment that once motivated long hours, low pay, and prolonged employment has weakened. Employees have considerable turnover and are more likely to apply to any hospital, regardless of its sectarian nature.

#### HOSPITAL MANAGEMENT ABROAD

The European and British hospital is managed as part of a larger entity, even when it appears to be a distinct unit, formally just as autonomous as an American hospital. Therefore, its goals are purposes other than its own self-aggrandizement, other than merely an instrument for the enrichment of its doctors. It is not really a "firm."

Religious attachments. Many of Europe's hospitals have been closely associated with religious sects for centuries, and they still are, despite changes in organizational form and despite reconstruction of the buildings.<sup>5</sup> The sect and its teachings are still present in everyone's thinking. Visible reminders of the sect are common in the interior decorating. Clergymen or nuns still dominate the governing boards and may still occupy the directorships. If so, the new lay financial experts are their assistants.

The humanitarian mission of the hospital therefore is still salient. Managers cannot be concerned exclusively with technical growth, market share, and helping the doctors become rich. If the State concludes that the public interest is served by financial restraint, such managers and governing boards cooperate rather than attempt self-serving end runs. Using the hospital to serve one's own interests is illegitimate. Having operated frugally in the past, the confessional hospitals of Europe are prepared to continue. They continue to try to work with lower staffing than the secular hospitals. New buildings with much new equipment do not arouse as much enthusiasm as they do in completely secular hospitals.

Financial restraint depends on the continued operation of the confessional hospitals under traditional management. If it secularizes -- like so many in the United States -- it pursues more expansionist goals. One reason for Holland's hospital cost explosion has been the mergers of small confessional and public hospitals in individual communities, producing a large modern secular facility under a resourceful lay management. The managers seek fame from the hospital's technical skills and they seek high income to pay off the large debts incurred to erect the new buildings.

Community attachments. Many European and British hospitals have been integral parts of their communities for centuries, often on the same site. The administrative offices are often full of reminders of these ancient and integral connections, such as portraits of past governing boards and engravings of the hospital as the neighborhood looked in past centuries. Annual events, such as banquets and special board meetings, include traditional ceremonies. Americans often call their volunteers "community hospitals," but this is a figure of speech compared to the European and British hospital's integration into an ancient community fabric. The American "community" is young and frequently changes in population; the American hospital is usually recent in date of founding and often moves about geographically when the buildings are replaced.

Constant themes of the European and British public and nonprofit hospitals are stability, service to the community, and charity to the

unfortunate. The managers and board seek more money to improve their services, and the doctors press for modern equipment. But it does not occur to them to press for rapid growth in scale or in functions.

The philosophy of stable service to the community not only inhibits ambitions to expand and add complex new functions, but it also obstructs phaseouts. A planner might think a community hospital obsolete and expensive, that economies of scale and clinical quality can be achieved in a new installation in the nearest city, that citizens should welcome the opportunity to take a short trip to the new and therefore better establishment. These schemes are invariably fought by communities with a fierceness that perplexes planners and finance officers of governments and sick funds. Such behavior appears economically and clinically "irrational," and so it is. A common result is that the community retains its hospital, converted to a different function, such as geriatrics.

Fostering esprit de corps among managers. Normally the hospital managers and the doctors would remain oriented toward particularistic groups, such as the religious sect or the community. The traditional ways of selecting and promoting the lay managers of confessional, secular voluntary, and secular public hospitals limit their horizons to the individual hospital and its reference groups. In nearly every country, the lay hospital administrators have come from commercial training courses, happened to get their first jobs in hospitals rather than businesses, and worked their way up. By selecting this career, they knew they were entering a lifetime of community service, they would not be businessmen manqués. They have been hired by the incumbent senior administrators and governing boards of each hospital. Once in senior posts, they have stayed on in that job until retirement or (in occasional cases) until invited to a senior post in a more famous hospital. But policies such as cost containment and developing a division of labor among hospitals require from managers of individual installations a much wider orientation. They must think of the system as a whole, how their establishments serve the public interest.

France has developed a method of orienting hospital managers toward the needs of the larger system, while continuing to administer

individual installations. French hospital management was staffed and oriented in the aforementioned traditional fashion for centuries, with merely a change of ownership from private associations to local governments during the Revolution. During the 1960's, national planning was begun, to produce a coherent system, raise standards, and eliminate waste. But hospital plans are notoriously ignored by lay managers and doctors. An essential part of the reform was improvement of the skills of the lay administrators. Normally in almost all countries, hospital administrators cannot easily be reached, since they are autonomous. Such a reform in hospital management was possible in France, because the national government may set standards for the civil servants employed by local governments.

As in many other sectors of French life, the national government created an elite corps of administrators in health, trained at a special graduate school (the Ecole de la Santé Publique), and based in an office of the national Ministry of Health. Posts in public hospitals throughout France are filled by the Ministry after consulting the governing boards. After graduation, the young members of the corps fill lower administrative positions. To be promoted, they apply for higher jobs opening in their current hospital or (more usually) elsewhere in the country. The administrator ultimately becomes a hospital director after service in several locations. He can then compete for openings as director in more desirable places. Other administrative employees who did not graduate from the School can still work their way up -- now also moving from place to place -- but the tone is set by the others.

The administrator is evaluated formally in his dossier in the Ministry and informally in the grapevine. On the one hand, he must excel in implementing national policies, such as running hospitals efficiently and economically. On the other hand, he must also please his hospital's governing board and the local community. Each board is headed by the mayor, includes members of the community council, and includes other local notables. The manager must mollify the hospital's medical staff. An administrator who can accomplish all this successfully will rise in the competition for better posts.

An administrator must be deeply involved in the demands of the governing board, doctors, and citizens of his current hospital. But he cannot fail to think about the policies of the country as a whole. His job is to fit local interests into national policies. Compared to other countries, French hospital administrators seem more cooperative with the rate regulators, who are other civil servants from the Ministries of Health and Interior in the local prefecture. They seem less aggressive in pushing proposals by doctors for new services that would duplicate those in other hospitals, more cooperative with plans for regional divisions of labor among hospitals. They seem more cooperative with national cost-containment policies, such as closing beds and limiting personnel to the ratios in the Ministry's guidelines.

No other country has anything like this. Until recently, the principal lay administrator of each hospital was a minor official; the finance officer was no more than a bookkeeper. But lay management grows everywhere in importance and size, because every hospital becomes bigger, more complicated, and more involved with external payers and regulators. Training programs for students of hospital administration are recent and produce limited numbers of students. Postgraduate courses and special training institutes are offered by hospital associations in many countries, and they are growing in number and in prominence. But they are still short in duration and voluntary in participation. One method of widening hospital directors' orientations -- used by the Swiss hospital association and the Dutch hospital research institute -- is to bring together regularly the managers of the hospitals in each peer group created by the rate regulators. They critically discuss each other's performance from comparative statistical profiles, as well as discussing national policies.

An energetic hospital association -- as in Switzerland, Germany, and The Netherlands -- can build among the previously disparate managers considerable esprit de corps and awareness of public policies. But the association must clearly convey a message about the public good, not the tactics of winning out over everyone else. Having mobilized a strategically situated nation-wide profession, the hospital association then becomes a great political force, represented in national discussions

about hospital policy. The question of orientation then moves to a higher plane: do the leaders of the hospital association then seek only the maximum financial gain and the maximum freedom for the hospitals alone, or do they participate constructively in the solution of the problems of the economy and of health services more generally?

#### LESSONS FOR THE UNITED STATES

In the past, hospitals have not been like business firms, oriented toward their own growth and designed to produce higher incomes for their staffs and owners. Hospitals usually have been charitable community institutions, often part of a religious sect. Hospitals in the United States and in other countries would best be served by retention of such religious motives or equivalent moral convictions among managers. Moral standards are essential in maintaining trust and stability in every economic sector.\* The nature of the hospital's work -- alleviating suffering and anxiety, helping the poor, initiating and prolonging life -- requires a morality other than the self-centered pursuit of personal advantage by managers, doctors, workers, and the organization as a whole.

Hospital management is par excellence a field to be inspired by a conception of the public interest. An effective way to accomplish this is through a corps of hospital administrators, trained in a common curriculum and moving up in a national job structure. Each manager then acts as intermediary between community interests and national policy. With such a career line, the manager can be rewarded by his professional peers for running organizations economically and efficiently, not merely rewarded by his immediate employers and by the doctors for beating the

\*This idea was obvious to the originator of free-market economics. Adam Smith said that individual business firms could pursue their work and sales and could produce the greatest economic good "led by an invisible hand," but each individual's public behavior should rest on a strict moral code. Smith's The Wealth of Nations (esp. Book IV, Ch. 2, on market structure) was part of a program of volumes, proceeding from his The Theory of Moral Sentiments (esp. Part V, Section III, on "self-command").

system. With a larger reference group, the manager has a counterweight to the self-interested tugs from his employer, the community, and the medical staff. Rate regulation and hospital cost containment require the cooperation of the lay managers and of the doctors, and the managers are indispensable in interpreting public economic policies to the doctors.

## FOOTNOTES

1. Fees, hours, and income before and just after World War II are summarized in Seymour E. Harris, The Economics of American Medicine (New York: The Macmillan Company, 1964), pp. 121-164 and sources cited therein.

2. Bruce C. Vladeck, "Why Non-Profits Go Broke," The Public Interest, Number 42 (Winter 1976), pp. 86-101.

3. For example, Lawrence K. Altman, "Physician's Move to Industry May Reflect Widening Trend," The New York Times, 28 July 1981.

4. Robert H. Hayes and William J. Abernathy, "Managing Our Way to Economic Decline," Harvard Business Review, Volume 58, Number 4 (July-August 1980), pp. 67-77; and Hyman G. Rickover, "Getting the Job Done Right," The New York Times, 25 November 1981.

5. For example, most of Germany's nongovernmental hospitals retain their historic religious connections. The history of the Catholic hospitals and the continued vitality of their religious character in their management are recounted in Johannes Kessels, "Auftrag und Verantwortung des katholischen Krankenhausträgers," in Die Gestalt des Katholischen Krankenhauses (Freiburg i Br.: Katholischer Krankenhausverband Deutschlands, 1981), pp. 132-282.

## CHAPTER XV

### CONTROLS OVER UTILIZATION

#### ISSUE

Appropriate use of the hospital is essential for both cost control and for quality. Ideally, treatments and tests that are unnecessary are not done at all; necessary ones are done in the least expensive setting that is clinically appropriate; and they are performed in ways that are safe and beneficial.

The problem for the American hospital has been maintenance of standards when so many autonomous physicians are involved. Originally, each admitting doctor could do what he liked with "his" patients. The license to practice medicine was qualification enough.\* In nonprofit and many public hospitals, nobody is boss. Leading hospitals created "tissue committees," whereby the medical staff guarded against occasional deficiencies and identified individuals who should not operate. When organized accreditation and licensure systems developed for American hospitals, one condition was the existence of medical staff committees to review the necessity of utilization and to audit the quality of work. Among the many thousands of hospitals in the United States, these committees have varied in diligence.<sup>2</sup>

When Medicare and Medicaid were first enacted, hospitals were required to have utilization committees, like those in the earlier private accreditation programs. But they seemed ineffective, since the medical staff was monitoring itself. Hospital costs under Medicare and Medicaid greatly exceeded expectations. "Outsiders" -- least of all, laymen -- could not be assigned to review the work of doctors, because

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\*So long as he has the basic license and hospital admitting privileges, a physician without Board certification may operate. The result in such hospitals seems to be more operations, greater risks, and higher mortality.<sup>1</sup>

supposedly only doctors in the community could judge the special complexity of the medical decisions, because "outside interference" would precipitate mass withdrawals from Medicare and Medicaid. So, the law created monitoring agencies to be staffed exclusively by doctors who would understand the situation but would not be so personally involved as to cover up error and venality. The 203 Professional Service Review Organizations\* were not internal hospital committees but were associations of doctors in the larger communities, modelled after the medical care foundations that had originated in California. They would have their own staffs and budgets supplied by the Medicare Bureau of SSA (later HCFA). They were destined to become arms of the local medical societies because -- if they were to get off the ground -- the societies' active members would lead them. Their jurisdiction has been confined to the use of short-stay general hospitals, and office practice has been  
3 exempt.

#### DIFFICULTIES

Controls over any profession in every country are difficult to install. Education and licensure select entrants, but the members resist anything more. The professionals supposedly have a monopoly on the expert knowledge of what to do and oppose any surveillance by "outsiders," such as the laymen in sick funds and in health insurance carriers. Several professions (like medicine) are egalitarian: every licensed member is considered fully qualified and the equal of all others, and peer review is avoided.

Concurrent review of admission and stays. During the first years of Medicare and Medicaid, the unexpected costs were thought due in large part to unnecessary admissions and excessive stays. But how to identify such cases? And who should be the watchdog? The United States had always been unusual in its establishment of control committees within some hospitals. But they were inhibited by professional customs: many hospitals did not have them, and many committees were cautious.

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\*\*Not all became operational. During 1981, 187 existed.

Under the new PSRO reform, the hospital doctors no longer would be left to monitor each other; but all doctors in the area would monitor them through a representative system, including the doctors affiliated with other hospitals and those excluded from all.

A problem has been implementation in the American federal system: while the national office of the American Medical Association once favored cooperation with the PSRO's, every state society makes up its own mind, the state and local societies really carry out the programs, and many were opposed. Therefore, many PSRO's have never activated, most were delayed, and many existing ones are weak.

A further complication has been the multiple missions of the PSRO. Each is supposed to guard the government's money by reducing unnecessary utilization under Medicare, Medicaid, and Maternal and Child Health. This involves criticizing doctors and hospitals, advising government agencies to withhold money, and advising government agencies to drop doctors and hospitals from lists. Each PSRO is supposed also to promote improvements in the quality of care. This implies the opposite of punitive utilization controls: the PSRO must gain the confidence of deviant doctors and teach them to improve. Promoting the quality of care might increase costs, not reduce them. Questioned for overtesting, overtreating, prolonging stays, or repeating too many visits, a doctor might argue that he is simply careful -- an explanation enabling his colleagues on the PSRO to get off the hook.<sup>4</sup>

Without central direction and simple common criteria of achievement, the PSRO's have had a very mixed record. Some were very slow to start up, because of the obstacles of local professional politics. Some have shrunk from utilization control but have been active in quality improvement. The program has been the target of characteristic Washington cross-fire, confirming the misgivings of the doctors about government: HCFA has "demonstrated" statistically that the PSRO program now saves more than it spends each year; Congressional committees say that money has been wasted because of the many slow starts and because of the many weak PSRO's.<sup>5</sup> When the Reagan Administration came to power, it suddenly reversed the Executive Branch's enthusiasm for PSRO's, since they violated its free-market ideology on two grounds: the program was

a form of regulation imposed by government; the PSRO's themselves were professional cartels restricting competition.

PSRO's have been developing a powerful technique in cost control and quality control that will stir up much controversy with doctors and hospitals. But this presumes strict implementation, and PSRO's may be dissolved by then. America's detailed billing yields much information per case; its powerful computing permits many peer comparisions, such as distributions of data by type of case, by doctor, and by hospital. The computer's programs for selecting outlyers can quickly list overutilizers among doctors and hospitals. Or, it can identify doctors and hospitals that give unusual patterns of treatment for a particular diagnosis. Deviants can then be investigated, penalized, or dropped from lists.<sup>6</sup> Serious utilization control is very sensitive; perhaps a PSRO might succeed, since it would be administered by doctors, like a German Kassenärztliche Vereinigung. But doctors shrink from enforcing it and lawsuits are invariably filed -- even in less litigious societies than the United States -- arguing that exceeding a statistical average does not make a doctor an overutilizer, but the accusers must prove to the court abuse in every case. European judges usually reject these arguments and defer to the administrators, but some American judges in some states doubtless can be found to uphold them, causing suspension and compromise of profile-based utilization and quality control.

Utilization review by Blue Cross. Utilization and quality review should be institution-wide, for all users. They refer to general institutional practices. The necessary data base refers to a hospital's entire business.

But the distinction among American payers weakens the controls. PSRO's were never mandated for any hospital's entire case load but only to monitor those cases paid for by the Society Security laws -- i.e., Medicare, Medicaid, and Maternal and Child Health. To be paid under these laws, the hospital must have a PSRO, but its scrutiny of other cases depends on the wishes of the PSRO's leaders and of the hospital.

Other third parties have the same problems as the federal cost-reimburzers: some admissions may be unnecessary, some stays may be too long. Blue Cross Plans in some states attempted to discourage unnecessary

use of hospital services before the passage of the PSRO Amendments in 1972, by contracting with existing Hospital Utilization Review Committees. Several state insurance commissioners made rate increases contingent on utilization review efforts. Since then, several Plans contract with PSRO's to apply their concurrent review methods to Blue Cross cases, to discourage unnecessary admissions and excessive stays. Blue Cross Plan headquarters must rely on the PSRO's and Hospital Utilization Review Committees, since they lack the clerical staffs to monitor hospitals' current work quickly enough and lack the clinicians to investigate individual cases.

Some Blue Cross Plans have performed retrospective utilization review, usually by spot-checking and by investigating possible patterns of over-use. If several hospitalizations seem unnecessary or unduly prolonged, they threaten to refuse to pay. Usually they shrink from refusing, lest the hospital bill the subscriber. But sometimes they refuse, to demonstrate their determination to the hospital. Aberrant patterns have been reduced to the peer group averages by criticism.<sup>7</sup>

Utilization review by the commercial insurers. Judgments about overutilization and overcharging require calculation of group and institutional averages. Since they are the targets, hospitals and doctors refuse to calculate and deliver to payers statistics about their entire business. Only the Medicare fiscal intermediary, the state Medicaid bureau, and the Blues have sufficient volume in individual hospitals to calculate statistics. The commercial insurers individually have too few cases in the individual hospital but believe that as a bloc, they are victimized.

The private insurance companies during the late 1970's were willing to pool their data about utilization and charges, for both hospitals and doctors. HIAA's lawyers feared an attack by a provider under the antitrust laws. HIAA asked the 95th Congress for an exemption from antitrust liability for such pooling and class action, but no legislation was passed. Peer review systems were created for a few insurance companies in a few states, provided the medical association or hospital association agreed. At the time of writing, the United States Supreme Court is studying whether they violate the antitrust laws.<sup>8</sup>

Medical Necessity. Money can be wasted not only by admitting and keeping patients when they could be treated or could recuperate outside, but by use of dubious and excessively expensive therapies. Traditionally in America, every doctor is free to treat the patient as he thinks best, and every doctor is fully qualified. However, the professional consensus changes, and not all individuals keep pace; some deliberately adopt unusual therapies; technology assessment sheds new light on favorite methods.

To avoid paying for unnecessary methods, the Blue Cross national headquarters has listed nearly one hundred diagnostic and surgical procedures. Committees of doctors are set up in states with Plans participating in the Medical Necessity Program. If the treating physician makes a satisfactory case to the committee for a listed procedure, he will be paid by Blue Shield.

Another problem has been the great cost due to routine use of diagnostic admission batteries. Under the Medical Necessity Program, the hospital and doctor are paid for an admission battery only when the physician specifically orders it.<sup>9</sup>

The Medical Necessity Program is limited. It does not substitute the profession's judgment for the individual doctor's; he can still use and be paid for an unusual treatment if he argues that he deems it medically necessary, and he can use and be paid for an admissions battery if he signs for it. The Blues and their clinical advisors have no power of their own to disallow such claims. Under the federal organization of the Blues, Plans implement the Medical Necessity Program with varying strictness. The Program applies only to the Blues and not to other patients and claims.

#### CURRENT METHODS ABROAD

Every country has the problem of preventing unnecessary services that enrich doctors and hospitals by accident or design, and that drain money from sick funds and from subscribers. And every country has the problem of discouraging poor quality care. These tasks prove very difficult, since ultimately laymen -- or medical executives acting on behalf of the public -- must over-rule the judgment of doctors.

Medical staff structure. America's problem is to control the many and heterogeneous physicians with full rights to practice in the hospital. Leaving everything to an economic free market -- i.e., the patient picks a doctor, risks poor service, and changes when dissatisfied -- may not be good enough. Europeans make hospital medicine more orderly by limiting the number of senior physicians, and these are fully credentialled in their specialties. Where community doctors can work in hospitals, the establishments are the smallest, only the simplest care is possible, and the riskier and more difficult work must be referred elsewhere. Most European countries have chiefs of service, responsible for all the work in a specialty; they oversee the junior doctors and may have only one or two other seniors to monitor. The problem is how to control the senior doctor; Europe has no solution.<sup>10</sup>

Utilization control as a statistical byproduct of payment systems. Utilization control exists in several European national health insurance schemes for ambulatory care. The fee-for-service system of payment permits the sick funds to count numbers of acts for each doctor, the computer identifies the outlyers, and the sick funds' control doctors may ask them to alter their practices.<sup>11</sup> Patients in proprietary hospitals in France, Switzerland, and a few other countries are charged fees by the doctors, as under ambulatory care, and their sick funds or private insurance companies may have the computing capacity to compare individual doctors or individual proprietary hospitals with averages calculated from peer groups.

Payment of hospitals abroad is designed to be simple administratively: the sick funds in all European countries pay an all-inclusive (or nearly all-inclusive) daily rate, with all individual tests and treatments averaged in; each Canadian hospital gets an annual global budget from the Ministry of Health. Individual tests and treatments are recorded in the patients' charts, which usually go no farther than the hospital's files and which are never linked to costing data. Short summaries of each case upon discharge are usually sent to the national statistical office as the basis of the country's tabulations about hospital services, but they lack the information for claims review or quality audit. Therefore, neither the payment system nor the patient

reporting system yields the detailed data necessary for statistical utilization control of inpatient (or even outpatient) hospital care.

Excessive admissions and excessive length of stay are considered problems by payers. In particular, in every country with the all-inclusive daily charge, sick funds and governments fear that the method yields a profit during the patient's final days -- since he requires few treatments and less nursing attention -- and therefore the hospital director would like to keep his beds filled with convalescents. The problem is how to spot the "unnecessary" admissions and the "unnecessary" prolongations, since they are exceptions.

Utilization review over ambulatory practice is performed by sick funds, since they get itemized bills from the doctors and create a computerized data file.\* The sick funds have very limited leverage over inpatients admissions and stays, but no capability of monitoring the flow of inpatient tests and treatments. In theory, the medical staffs of the sick funds should approve the hospitalization of every patient in advance, but in actual practice approval is automatic and pro forma. Many admissions to the public and nonprofit hospitals are emergencies; and most of the other admissions are so unplanned that the sick funds cannot be notified in advance.\*\* As part of the admissions procedure in every country with national health insurance, the hospital notifies the patient's sick fund, to get a guarantee about payment. Usually the form mentions the diagnosis. The control doctors within each sick fund (called, for example, médecin de conseil in France and Vertrauensarzt in Germany) get copies. In most countries, the initial approval is given automatically for a certain number of days at the full daily rate, such

\*An exception is Germany, where a long history of bitter conflict over utilization between sick funds and doctors led to the creation of the Kassenärztliche Vereinigung in each province, an association of doctors for the processing of payments, like an American independent practice association.

\*\*Few admissions to proprietary hospitals are emergency, and most are by appointment. While the private insurance companies could screen and reject applications in advance to control costs, they dare not. Their raison d'être is to pay for private hospitalization whenever a customer wants it.

as twenty days by CNAMTS, the principal French sick fund. A few sick funds with a smaller and more manageable flow of paper try to differentiate the length of guarantee by the patient's diagnosis.

Control doctors make occasional visits to hospitals. They can look at records of their subscribers and may occasionally suspect that an admission was unnecessary. They have too much work to do a thorough study of all the hospitals and to challenge substantial parts of the caseload. They have little leverage over the initial admissions: if the sick fund refuses to pay, the subscriber is stuck with a bill, since he has already been in the hospital for several days. But their suspicions about the laxity of certain hospitals and of certain chiefs of service may ultimately be transmitted to the rate regulators by the sick funds.

The sick funds have more leverage over length of stay. The hospitals must renew their guarantees in advance. For example, as the twentieth day approaches for a patient in a French hospital, the establishment must notify the sick fund of any intent to keep the patient longer, supported by the service chief's explanation. The sick fund control doctor can then recommend continued coverage for a certain number of days at the full rate or at a reduced rate for convalescence. If the latter, the hospital may bill the patient for the rest, activating his preference for going home; or, the hospital may settle for the reduced rate and look for new and more profitable patients.

In every other country, the sick fund and its control doctor either renew stays of all patients at fixed intervals or review the files of patients from time to time. Whenever a German control doctor visits a hospital, he looks at the records of patients who have been there for a substantial time (as the sick fund defines it) and asks the chief of service (or his assistant) about the prospects for discharge. If the review is not automatic and lacks fixed intervals, as it does not in Germany, control is weaker, stays drift longer, and hospital costs are higher.\*

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\*American sick funds that pay doctors directly, such as some state Blue Shield Plans, also employ control doctors who question physicians who send in far more than the average number of bills. The

The control doctors are usually inhibited from questioning the clinical judgments of the hospital specialists. The chief of service is the leading physician in his field in the region. He looks down on the sick funds' control doctors, who often are former GP's from small towns. The control doctors are more confident in questioning the office doctors over possible overutilization.

Possibility of referrals. The sick funds can be critical of lengths of stay if the hospitals constitute a true system, with establishments for extended care, convalescence, and custody of the elderly. Then the patient is merely transferred from one place to another with cheaper clinical care and different payment principles, such as cost-sharing by the patient from his pension. One reason why German sick funds are more permissive about stays in acute hospitals is the absence of nursing homes.

Review by rate regulators. Sick funds and governments rely on rate regulators to detect hospitals with unusually high rates of servicing and to investigate. All hospitals submit their recent cost experience and many utilization statistics when asking for higher charges. All data are computerized by the rate regulators, and often by the sick funds and hospital associations too. When a hospital seems to have higher costs than other members of its peer group on any lines of its budget, the regulators usually seek explanations by comparing the utilization statistics for tests and patient-days. Often they compare populations of catchment areas, to detect whether a more expensive hospital's higher admissions and higher patient-days are due to a larger, more aged, or more disease-prone service area. The sick funds' control doctors may hesitate to argue with a chief of service, but the regulators do not; a hospital may dismiss the criticisms of a sick fund as self-serving, but they must heed the regulators. It is very common for rate regulators to recalculate a hospital's budget if it cannot justify higher utilization or greater service intensity, and to award a lower

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most formalized review of hospital admissions and stays is the Medicaid Cost Containment Program of New York State. Since 1976, the Department of Health has assigned physicians and nurses to review Medicaid patients and nurses to review Medicaid patients in several hospitals, to recommend the propriety and length of hospitalization.

daily charge. Since they have the same data files as the regulators and sick funds, the hospital associations in several countries (such as Switzerland and Holland) can detect individual hospitals that exceed peer group averages and advise them about improvement.

Length of stay penalties are one of the automatic formulae in New York State, mentioned in Chapter VI, supra. If the greater number of days is not associated with a greater number of admissions, a hospital is paid by Medicaid and by Blue Cross only about 20 per cent of the average per diem for each extra day beyond the prediction at the start of the year. The 20 per cent represents the variable costs; the hospital does not collect for fixed costs which it should not have added, so therefore it lacks the incentive to prolong stays. Such reasoning is common among European rate regulators to discourage prolongation of stays, but it is not applied automatically. During the end-of-the-year settlements, the regulator investigates why the number of days exceeded predictions and applies any reductions in pay judgmentally. The results can be easier or tougher than the New York formula.

#### ENCOURAGING EXTRAMURAL ALTERNATIVES

Issue. The hospital has always seemed synonymous with advanced care. Until the boom in office practice after World War II, the American ambulatory care physician was perceived to be a man with a bag, who made house calls and received visitors in a quaint office with leather upholstery. His specialty was sympathy. He would refer anything uncertain or complex to a specialist, who would often do his work in the hospital.

When private and nonprofit health insurance developed, it was designed to pay the larger bills, presented by hospitals. Since the office doctor did little and could charge only low fees, insurance was not designed to cover his work: a patient could afford his fees, and administration would be at least as expensive as the services. Public subsidization of health facilities built up the hospitals.

Many office doctors in the United States obtained the right to treat their patients in hospitals, instead of losing the patients to

specialists. Since the hospital was better equipped than his own office and since the hospital's equipment was "free" -- the patient rather than the doctor paid for it -- the office doctor performed much diagnostic and therapeutic work there. The hospital was traditionally organized to do its work upon inpatients, and therefore many private and insured patients had to be formally admitted for simple things. Many nonprofits and public hospitals maintained outpatient services, but often these were drop-in charities for persons without family doctors.

Difficulties. The acute hospital became much more complicated than other organizations, because widely diverse services were performed under the same roof. Some patients were healthy, staying for short periods for tests, simple treatments, or observations. Some were truly sick or injured. Others were convalescents. The environment was not psychologically appropriate for the short-stay and convalescent patients. They risked contagion.

Because many institutional costs were averaged over all patients' per diem charges, much cross-subsidization resulted. The less expensive short-stay and convalescent patients were overcharged with the costs of the acute patients. Hospitals and doctors had incentives to keep convalescent patients in their beds. The hospital earned more than it spent on them; the patient's insurance might cover doctor's fees only during hospitalization. Convalescent patients were little trouble, and the doctors and nurses could concentrate on the acute patients.

Hospitalization insurers -- and particularly those committed to payment in full, like Blue Cross -- have pressed to eliminate unnecessary hospitalization. Blue Cross Plans have tried to refuse payment for admissions merely for testing. Most offer full coverage for preadmission outpatient testing, same-day surgery, and outpatient convalescent care.<sup>12</sup> Insurance policies cover inpatient acute hospitalization only for limited periods, giving patients a financial incentive not to stay too long. Medicare covers nursing homes upon referral from an acute hospital, so the patient and doctor will be willing to move there. Blue Shield Plans have steadily increased coverage of doctors' fees for office practice and hospital day care, when originally they were designed only for hospital care. Blue Cross and Blue Shield have merged, in large part to coordinate

intramural and extramural work; the doctor will receive full payment in the most appropriate site.

New forms of practice and financing have been created. Health Maintenance Organizations and other groups of ambulatory care doctors are installed together in advanced facilities. They can use equipment and consult each other without relying on day care or inpatient care in a hospital. If the group is prepaid and the doctors share net receipts, they have an incentive to avoid referrals to hospitals.

Evolution abroad. Every country had the same history as America: simple care was given by the office doctor, and he was set up largely for home visits; more complex and intensive work was done in the hospital; no intermediate facilities existed. One difference from American history was financing: insurance abroad began to pay the office doctor, but eventually hospital benefits were added almost everywhere. National health insurance in Europe lacked the American propensity for categorical programs in both the public and private sectors, which led to the American distinction between hospital insurance and ambulatory care insurance, unbalanced toward hospital care.

Categorical distinctions are peculiar to the Anglo-Saxons, and the other two countries had them. Blue Cross -- without Blue Shield -- had spread through Canada but had limited coverage. Several provincial governments enacted hospital benefits plans during the 1950's, the national government then agreed (in 1957, beginning in 1958) to share half the costs of all hospitalization, and all provinces enacted programs. Ottawa also enacted a shared-cost hospital construction program to accommodate demand. Not until 1968 was ambulatory care supported by a similar federal-provincial shared cost program, and extramural services have never received comparable facilities grants. During the decade before the start of Canada's Medicare, patients preferred in-patient to extramural care, since the former's non-physician costs were "free" while the latter's required private insurance and out-of-pocket. (Doctors' fees in both settings were private transactions until Medicare governmentalized them.)

Until enactment of the National Health Service, Great Britain separated hospital finance from ambulatory finance, but its bias was the

reverse of North America's. National Health Insurance in Britain (1911 to 1948) covered ambulatory but not intramural care. Nonprofit hospitals covered their inpatient care by contributory schemes, limited nonprofit insurance, patient out-of-pockets, and charitable donations; local authority hospitals were subsidized by local taxes. All hospitals were underfunded and underdeveloped; the bankruptcy of hospital services by the 1940's seemed beyond redemption by addition of hospital benefits to NHI, as in Europe, and adoption of a full-scale NHS seemed the only solution. During the many years of underfunding of hospitalization, Britons developed habits of reliance on general practitioners, self-dosing, and neglect in lieu of entering the hospital, and low admission rates continue today. Political pressures have never built up strongly over hospital provision; capacity is limited, and waiting lists exist for cold surgery.

Current methods abroad. In the past, as in the United States, Europeans did not think through whether the financing procedures were causing work to be done in the hospital, when it could be done more cheaply outside. However, this is now being realized belatedly.

Moving serious medical and surgical care out of the hospital into extramural arrangements requires much ingenuity and experimentation. The country with by far the largest number of these arrangements is the United States. It is not only America's high hospital costs that account for these shifts but the flexibility of the entire system. The absence of standard structures and the American culture of inventiveness induce voluntary associations, for-profit entrepreneurs, the hospitals themselves, and medical groups to offer new forms of delivery. The payment system for intramural and extramural care is not yet frozen around certain common forms of practice. Many doctors have offices (or group affiliations) as well as hospital privileges; and they are willing to do some work extramurally if the facilities are not inferior and if they collect the same pay.

An advantage of national health insurance is administrative simplicity by standardizing the procedures for pay around conventional forms. New forms can be introduced, but they may have to be added to fee schedules and contracts in negotiations between sick funds and

medical associations. Or they require new regulations by the government agency overseeing NHI, and such regulations must always be acceptable to the providers and sick funds. An innovation in health delivery is a challenge to established providers, and they can approve slowly. Day care, home care, ambulatory surgery, nursing home care, and other alternative methods ultimately are added to NHI benefits, but slowly.

At times, jurisdictional rivalries among providers block change abroad. For example, the early peace treaties between the medical associations and sick funds in West Germany gave financial administration over ambulatory practice to the groupings of office doctors, the Kassenärztlichen Vereinigungen. Hospital medicine was to be paid for under the daily rate (pflegesatz) negotiated between the sick funds and the hospitals. Hospital doctors could see patients privately and charge them privately. As a result, hospital doctors have never been able to treat patients under NHI and to send bills to the KV's.\* West German hospitals lack the OPD's that give hospital-level care on an ambulatory basis in many other countries. Germany's high admissions rates and long stays are probably due in large part to this gap. On the other hand, office doctors do much advanced work in their well-equipped offices and in small private clinics set up for very short and cheap stays. Any attempts to involve the hospital specialists in day care and in extensive outpatient work founder on the regulations barring them from billing for ambulatory treatment under NHI.

Providers are private nonprofits and local governments under NHI, and extramural substitutes cannot be used unless these providers are willing to create them. A government running a National Health Service can accomplish much more. If the Ministry of Health decides its money can be used more efficiently and more humanely in new extramural facilities, it creates them. Therefore, Britain has more new forms of home care, day care, combinations of social and health services, etc., than any other European country. Like the hospitals themselves, these programs are administered by District Health Authorities. Day surgery and other

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\*The only exceptions are the few office doctors allowed to practice part-time in hospitals that lack full-time specialists in their fields (the Belegärzte).

day care are conducted in some hospitals with adequate facilities, avoiding the need to go on waiting lists for the highly occupied beds. Much of the community care depends on the talents of public health nursing and home visiting, long established in British health services. As always, the work depends on the cooperation of office doctors and hospital doctors. Provided that their independence is not challenged, they cooperate; but their apprehensions inhibit certain initiatives, such as the development of health centers.

The hospital's OPD and some community facilities are used readily in Britain, because beds are scarce. But if beds are plentiful, it is hard to induce doctors to break their habits of hospitalizing all but the simplest cases. That is particularly true if the doctor will surrender control over the patient, sending him to a health center staffed by others. The health centers may develop their own patient loads, while hospitalization is not greatly reduced.

Few countries can reduce the load on acute services by extensive referral to nursing homes. Few countries have many. The other Anglo-Saxon countries have nursing homes, but (as in the United States) they are unusual in their creation as for-profit establishments with limited staffs, not created by mainstream non-profit associations. The official payment schemes in Great Britain and Canada do not cover them at all; they are included under American Medicare, as referral centers from acute hospitals. Their status under American Medicaid has been contentious.

A system can be organized to give nursing homes a recognized place with adequate funding and a good clinical staff. The solution in France is to integrate them with the public hospitals. Once the French hospital was adjacent to the church and housed the homeless elderly as well as the acutely ill. Gradually during the nineteenth and early twentieth centuries, the two functions were separated: a new building was created for the ill, and the elderly stayed in the original. The same director, governing board, and medical staff handled both the original facility for the elderly (the "hospice") and the newer hospital.

After World War II in France, a still newer building was often erected, resulting in a group of three in many towns throughout the country: a new acute hospital; an extended care facility in the older

hospital building; and the hospice. Budgets are submitted to the prefect for all three parts and daily charges are issued for all (i.e., rates for several acute specialties; rates for one or two extended care specialties; and the rate for the hospice). The same management and medical staff run all three establishments and can easily transfer patients back and forth according to clinical need. The control doctors of the sick funds are alert to the possibility the patient may be kept too long in otherwise empty beds in the more advanced establishments, where the daily rates are higher. But otherwise, the directors and doctors have no greater financial and clinical disincentives against referrals.

#### LESSONS FOR THE UNITED STATES

Utilization restraints and financial incentives can induce physicians to treat patients outside the acute hospital. But the extramural facilities must exist, be available, and be coordinated with the hospitals and doctors. This requires organization and planning. There is no assurance that a completely free market will supply the appropriate number of extramural facilities. In fact, if extramural care is cheaper -- as it is supposed to be -- private capital may avoid it.

Utilization and quality review over hospitals and doctors will be resisted, since it strikes at their incomes and egos, it deprives them of independence. Hospitals and doctors never cooperate voluntarily with government and sick funds in allowing investigations and supplying data. Utilization review must rest on law and on conditions for payment.

Utilization and quality review require merger of data for all payers within each hospital and for all hospitals in a peer group. Hospitals and doctors will resist this.

Utilization and quality restraint requires a strong commitment by the medical profession itself. Hospitals must be led by service chiefs committed to economy and quality. Sick funds and public agencies involved in such monitoring need employ physicians whom the profession respects. The medical profession must be organized, with an active association committed to cost-effectiveness and quality of care; the profession cannot be merely a collection of individuals.

## FOOTNOTES

1. Osler Peterson, "Why Do High Surgery Rates Raise Case Fatality Rates?", American Journal of Public Health, Volume 71, Number 6 (June 1981), pp. 574-576.

2. The history and performance of control committees are in Milton Roemer and Jay Friedman, Doctors in Hospitals (Baltimore: The Johns Hopkins Press, 1971), *passim*, esp. pp. 223-227.

3. Described in John W. Bussman and Sharon V. Davidson (editors), P.S.R.O.: The Promise, Perspective, and Potential (Reading, Mass.: Addison-Wesley Publishing Company, 1981); and Michael J. Goran et al., "The PSRO Hospital Review System," Medical Care, Volume 13, Number 4, Supplement (April 1975).

4. The contradictory demands on the PSRO from cost containment and quality improvement, and the contradictory implications for costs are discussed by Harry M. Rosen, "Conflict in Regulatory Goals" (New York: Graduate Program in Health Care Administration, Baruch College/Mount Sinai School of Medicine, City University of New York, 1977, paper prepared for annual convention of the American Political Science Association).

5. Compare Professional Standards Review Organization 1979 Program Evaluation (Washington: Health Care Financing Administration, 1980) and "The Effect of PSROs on Health Care Costs" (Washington: Congressional Budget Office, 1979); "Wasted Health Dollars: Evaluation of Professional Standards Review Organizations," Hearing before the Subcommittee on Oversight and Investigations of the Committee on Interstate and Foreign Commerce, House of Representatives (Washington: U.S. Government Printing Office, 1980).

6. The HCFA report cited in footnote 5, supra, pp. 128-138.

7. "Utilization Review: An Overview" (Chicago: Blue Cross and Blue Shield Associations, 1979); and Janice M. Moore, "Utilization Review: The Blue Cross Perspective," Quality Review Bulletin, June 1978, pp. 29-31.

8. Union Labor Life Insurance Company v. Pireno, October Term, 1981, No. 81-389.

9. Johanna Sonnenfeld, "The Blue Cross and Blue Shield Association's Medical Necessity Program," Voluntary Effort Quarterly, Volume 3, Number 2 (June 1981), pp. 5-8.

10. The most famous case of the inability of the system to control a deteriorating chief before the date of his automatic retirement is described in Jürgen Thorwald, The Dismissal: The Last Days of Ferdinand Sauerbruch (New York: Pantheon Books, 1962).

11. Described in William Glaser, "Controlling Costs through Methods of Paying Doctors: Experiences from Abroad," in Stuart O. Schweitzer (editor), Policies for the Containment of Health Care Costs and Expenditures (Washington: U.S. Government Printing Office, DHEW Publication No. (NIH) 78-184, 1978), pp. 225-230.

12. Counts of the numbers of Blue Cross Plans offering each type of extramural benefit during the mid-1970's appear in Walter McNerney's testimony in National Health Insurance (Washington: U.S. Government Printing Office, Public Hearings before the Subcommittee on Health, Committee on Ways and Means, House of Representatives, 20 November 1975), pp. 1216-1217.



## CHAPTER XVI

### CONCLUSION

This chapter presents some central themes. It also summarizes discrete facts from earlier in this volume.

The chapter cannot repeat everything appearing earlier. At the end of each chapter in this volume is advice to the Americans, in the light of foreign experience in each chapter topic. At the end of each national monograph produced by this project is a summary chapter of advice to the Americans inspired by that country's system of hospital finance.

### NEED FOR WIDER PERSPECTIVES ABOUT HOSPITAL FINANCE

Hospitals until the mid-nineteenth century were not part of the cash economy of Western countries. Their revenue and expenditures have increased spectacularly as they have become more normal economic organizations; in every country, their spending in nearly every year has risen faster than the CPI, and they absorb a steadily higher proportion of GNP. A few developed countries have succeeded in applying strict financial limits while maintaining adequate (if not ideal) care. Others are bringing the annual increases down closer to the CPI. The United States has a stop-and-go pattern: lower increases when regulation is applied or threatened, spurts when regulators are on the defensive politically. Initially in all countries, hospitals outstripped other economic sectors in costs; for decades, they were encouraged to do so.

The problem today goes beyond the choice between continued rapid expenditure increase and tying aggregate national hospital spending to other economic indicators. The hospitals were intentionally modernized throughout the twentieth century in every country. The problem now is large medical and economic policy, viz., the amounts of work to be done by hospitals and by other medical and social facilities;

types of patients (if any) who should get second-best or no services.

The hospital and many other medical services have been charities for the unfortunate, and they still are. Most countries have now made hospitals appropriate for all social classes and for all ages; and they have devised prepayment methods to guarantee the costs of hospitals when point-of-service payment by patients would generate less money than the hospital expected. Hospital services cannot easily be differentiated and calibrated for each payer, so that the person with less cash and with lower insurance gets precisely less service. Hospital costs in every country more or less are spread over all patients according to "need," and reimbursement is spread over them according to their third parties' resources. Historically, third parties have widened their coverage and have increased and equalized their resources. The modern methods of including everyone under some third party and collecting funds conceal the fact -- as true today as a century ago -- that many people lack the money for the present levels of hospital care. The social solidarity that was first hinted at a century ago is now generally practiced in hospital care -- somewhat less in some countries (like the United States) than in others. Critics who advocate more personal responsibility and personal payment in buying insurance and in paying for hospital really advocate restoration of the older pattern of differential services by income, with the very poor and elderly getting little or nothing. This would certainly reduce medical spending, since it would reduce medical services. It would probably reduce demand by increasing mortality.\*

But the aged and the poor will not "leave the market" if they lose full coverage by social security and public welfare. Unlike a market for washing machines, nonprofit and public hospitals will continue to get such patients in the outpatient and emergency departments as they have for centuries. The financing problem will remain the same: how can the hospital cover its costs; what services should it offer to what people; if some people are turned away, what should happen to them?

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\*The universal trend toward lower mortality rates and longer life expectancies can be reversed, as the USSR has inadvertently demonstrated recently. The victims seem to be infants and the causes -- in a national health service -- seem to be supply constraints rather than demand constraints.

The current literature about manipulating monetary demand evades all the fundamental issues in health policy.

Amidst the American criticisms of overspending and overprovision nowadays, one should not lose sight that the main aim of health policy is adequate services. Defining and satisfying the standards of "adequacy" is a greater challenge than the evasion of saying that whatever self-payers choose to pay for is ipso facto sufficient. The definitions of adequate servicing appropriate for non-medical consumption are not applied to health in actual practice in the United States or in any other developed country.

Health policy, like all policy, requires strategic thinking. It is not enough to pursue one topic, such as hospital cost containment, in isolation. It must be fitted into a set of policies in health and in other fields, as the experience of the United States and of other countries shows.\* Such strategic thinking is particularly difficult in federal systems like America's, but experiences in Germany and Canada point the way.<sup>2</sup>

#### EFFECTS OF PAYMENT METHODS

Some writings about hospital finance seek the best unit of payment, which will promote certain objectives and avoid others.<sup>3</sup> But this is too abstract. Any payment technique is part of a larger administrative arrangement within the hospital and between the hospital and external forces (payers and monitors). How any payment procedure works in practice depends not on its theoretical incentives but on the entire administrative arrangement. Certain positive incentives might be suppressed in practice in one situation; in other arrangements, certain perverse incentives may not appear or might intensify. Any payment

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\*The Carter Administration's hospital cost containment policy was presented as a discrete theme. It was not integrated with the Administration's policies about national health insurance, welfare, or other topics. The hospital cost containment policy was changed without inspecting the repercussions on other policies. The spectacle of disarray resulted in the legislative defeat for all the proposals and the electoral defeat of the President.<sup>1</sup>

method can be made to work well or badly; the organizational problem is to construct the full complex.

Detecting effects of a specific device is difficult because so many confounding variables must be held constant. The trend in the world is toward standardization within each country and toward some variations among countries. To identify effects of a payment method statistically, one must match hospitals in several countries. A few comparative studies of hospital use and hospital costs have been attempted; they are essential experience in the development of reliable comparisons and inferences; but they have not yet achieved the best matching of organizations and catchment areas.<sup>4</sup> One must understand the institutional dynamics in all the countries in such comparisons, in order to make inferences; blind statistical comparisons are not fruitful.

With such qualifications, one can identify some characteristics of units of payments, as they operate in hospital services abroad:\*

1. All-inclusive daily charge:

(a) Strengths:

- (1) Administrative simplicity.
- (2) Economy in billing. Lists of patients and their days are sent to sick funds.
- (3) Usually all payers are on the same footing. Rivalry among them in the coverage of basic hospital services is reduced, and they can form common negotiating fronts. Their competition moves to other subjects. (Of course, some observers might consider such standardization and collectivization a weakness.)
- (4) The work and income of the doctors are controlled more closely by the hospital organization.

(b) Weaknesses:

- (1) Not enough data about treatments.
- (2) If the daily charge is uniform, costing by type of patient is hindered. Some payers subsidize others.

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\*I will not discuss methods for which no foreign experience exists, such as payment by each admission.

- (3) Incentive to avoid shortening stays.
  - (4) Because the hospital management and sick funds do not get prompt information about services, utilization control over individual doctors' work is weak.
  - (5) If the daily charge includes amortization of debt, new equipment and programs can proliferate.
2. Itemized billings, more or less. The minimum itemization is a daily charge without the doctors' fees. The maximum itemization is highly debundled.
- (a) Strengths:
    - (1) More statistical information about the work of the hospital and of the doctors.
    - (2) Cost-center accounting within the hospital is feasible under the more itemized methods.
    - (3) More accurate costing of types of patients. Accurate individual billing is possible.
    - (4) Costing of individual procedures conduces to the efficient assignment of personnel, space, and equipment. The costs and benefits of individual procedures can be compared.
    - (5) Since individual procedures are recorded, utilization control is possible.
    - (6) Incomes of some doctors can be higher -- a strong point for them. Doctors' incomes are more differentiated, determined more by their own efforts.
  - (b) Weaknesses:
    - (1) Incentive to proliferate tests and treatments in inpatient and particularly in outpatient departments.
    - (2) More administrative work for hospitals and payers.
3. Global budget:
- (a) Strengths:
    - (1) Spending for all hospital services in the region or country can be controlled and predicted.
    - (2) Fits planning of facilities and investments.
    - (3) Administrative simplicity.
    - (4) Hospital spending can be tied into larger expenditure

- planning, such as maintaining a constant proportion of GNP.
- (5) Payers can plan their premiums and taxes with greater certainty.
  - (6) Health managers and doctors must work more closely with officials in other economic sectors, they must become involved in public priority-setting more generally.
- (b) Weaknesses:
- (1) Little data about treatments and costs of procedures.
  - (2) Utilization control over work of individual doctors is handicapped by lack of data.
  - (3) Incentive to save money by underserving.
  - (4) Usually no cost-center accounting within the hospital.
  - (5) Hospital managers complain that global budgeting is often used to squeeze the hospitals unduly. (As in many aspects of hospital finance, this is not inevitable: it depends on how global budgeting is administered, whether payers cover deficits.)
  - (6) Can become involved in politics, and hospital spending might experience stop-and-go fluctuations.
  - (7) In practice, hospital managers are not given all the discretion they expect. May be given a fixed budget and expected to keep all existing services open. The grantors who constrain the money and services do not always think through how to deal with excess demand.

#### IRREVERSIBLE FORCES CREATING HIGHER COSTS

Several forces cause hospital costs to rise in every country:

##### 1. Personnel costs

- (a) Higher wages for hospital workers. Once they were paid in kind and received little cash. When they began to get cash wages, payments remained low for a long time. Now the workers seek at least parity with their peers.
- (b) Shorter hours. Now the workers seek parity with their peers. Therefore, more persons are needed for the same work.

- (c) Greater service intensity in medical care. More technicians and hospital workers perform diagnostic and therapeutic work on a patient than in the past.
  - (d) More leisurely work pace. Once hospitals were frenetic places, with dictatorial supervision. Now more persons are needed for the same work.
  - (e) A few categories once paid little now expect very high salaries, such as doctors and administrators.
2. Buildings are far more expensive to operate than in the past. Require more heating, electricity, maintenance. Prices of power and maintenance materials rise.
  3. Amenities. Patients expect more comforts than in the past -- or so the hospital managers think. Simple objects like beds have become fancy.
  4. Equipment for diagnosis and therapy:
    - (a) More numerous, more complicated, and more expensive than before. Often pressed into use before value is established, since the value can be learned only by extensive use.
    - (b) Made obsolete at an accelerating rate, or so the instrument companies persuade the doctors. Higher prices depreciated with a shorter expected life raise the capital component of hospitals' daily costs.
  5. Greater utilization. Affects the outpatient department in some countries more than the inpatient departments. In many countries, rise in admissions is offset somewhat by shorter stays.
    - (a) More people come to the hospital.
    - (b) Modern medicine saves many people from death but cannot produce total cures. So, a large number of persons are invalids, frequently visiting hospitals and doctors until old age.

One must distinguish between the forces making for higher unit costs and for higher costs for the entire system. The universal trend toward shorter stays and greater service intensity increases unit costs and in part reduces total costs for every system -- insofar as effort per admission remains constant. But, in addition, effort is added to each admission, calling for greater equipment, supplies, and personnel, and these add to the costs of every system.

The foregoing sources of high costs are very difficult to reduce substantially. Some are inherent in social trends in the labor force; health care has become more like other sectors, and political barriers prevent it from being returned to the day of very low labor costs. Some sources result from trends in clinical medicine, and the higher costs can be reversed only by restoring the earlier patterns of higher death rates and shorter life expectancies.<sup>5</sup> But, of course, limited economies can be accomplished through greater efficiency.

#### DETERMINANTS OF COSTS

The motive for most American research about hospital finance during the last decade has been restraint on rising costs. Experiences abroad show certain administrative arrangements that restrain costs, others that allow spending to increase. In the real world, of course, each administrative device is combined with many others in a system; some other characteristics have the same effect, others work in opposite directions. My observations suggest the following are principal influences on levels of costs, as they usually operate in practice abroad. These are organizational influences, which could be emulated in the United States -- if reduction of spending is a policy goal.

| <u>Determinant</u>                       | <u>Higher Costs</u>                     | <u>Lower Costs</u>                                   |
|--|---|--|
| Method of Payment                        | Rates related to services rendered      | Global budget  |
| Pricing and billing                      | Itemized                                | Bundled  |
| If global budgeting and public grants    | Bottoms-up                              | Top-down   |
| Source of money                          | Insurance, especially private           | Government Treasury                                  |
| <b>Characteristics of payers:</b>        |   |  |
| (a) Number                               | Many                                    | One or few   |
| (b) Relations among payers               | Rivals                                  | United   |
| If rate regulation, nature of the agency | Commission dominated by interest groups | Line agency of government, staffed by civil servants |

| <u>Determinant</u>   | <u>Higher Costs</u>                                   | <u>Lower Costs</u>                     |
|--|---|--|
| Procedure of the regulator or grantor:   |   |  |
| (a) Parent bodies issue guidelines about allowable increases                                   | None. Or, few and vague.                              | Yes                                    |
| (b) Can prescribe allowable increases in utilization, not merely rates                         | No  | Yes                                    |
| (c) Can authorize any new jobs in hospital   | No  | Yes                                    |
| (d) Have voice in planning of building and programs  | No  | Yes                                    |
| Uniform reporting by hospitals to regulators and payers  | No  | Yes                                    |
| Interim monitoring during the year by the regulator or grantor                                 | No  | Yes                                    |
| (a) Expenditure reports  | No  | Yes                                    |
| (b) Liaison officers   | No  | Yes                                    |
| Possible increases in budget or rates during year  | Yes   | No                                     |
| Carryover of deficit into next year  | Yes   | No                                     |
| Relations between reviews of last year's expenditure report and next year's prospective budget | Combined  | Separate                               |
| Regulator or payer can examine the hospital's books  | No  | Yes                                    |
| Scope of hospital budget review by regulator or grantor  | Inpatient only  | Inpatient and outpatient               |
| Subsidies by government, if any  | To sick funds   | To hospitals directly                  |
| Planning of hospital services:   |   |  |
| (a) Does it exist  | No. Or, indicative planning with voluntary compliance | Yes, with sanctions for non-compliance |

| <u>Determinant</u>  | <u>Higher Costs</u>                   | <u>Lower Costs</u>                            |
|---|---------------------------------------|---|
| (b) Coordination between planning and reimbursement.<br>If hospital refuses to cooperate: | Payer reimburses patient at high rate | Payer reimburses patient little or nothing    |
| (c) Source of money for new building and major equipment                                  | Borrowed, with amortization in rates  | Granted, with no amortization                 |
| <b>Organization of hospital:</b>  |                                       |   |
| (a) Position of individual establishment  | Autonomous                            | Part of regional or larger system             |
| (b) Orientation of the manager  | His single unit                       | Larger collectivity                           |
| (c) Function  | Teaching                              | Non-teaching                                  |
| <b>Physicians:</b>  |                                       |   |
| (a) Medical staff structure   | Open                                  | Closed  |
| (b) Relations to hospital   | Hospitals compete for doctors         | Doctors compete for hospital posts            |
| (c) Authority of regulators or grantors over pay of senior hospital doctors               | No                                    | Yes   |
| (d) Payment of senior doctors   | Fees                                  | Salaries                                      |
| <b>Wage determination:</b>  |                                       |   |
| (a) Scope of decisions  | National or regional                  | Each unit                                     |
| (b) Number covered by agreement   | Entire hospital work force together   | Separate contracts, each for different period |
| (c) Connection with rest of labor force   | Linked                                | Not linked                                    |
| <b>Standards by law:</b>  |                                       |   |
| (a) Quality of personnel  | Strong                                | Weak  |
| (b) Safety  | Strong                                | Weak  |

Some devices are by definition a reduction in costs and in utilization, so I have not listed them above:

1. Very strong controls over utilization. Some people -- classified by such personal characteristics as age or classified by clinical diagnosis -- are not admitted. The greater the limits, the lower the operating and capital costs of hospitals.
2. Very strong controls over supply. At once, the controls limit capital costs. If supply is much less than demand and if patients must queue, the operating costs of the total hospital system will be lower than otherwise. For-profits may raise their prices and therefore increase their revenue and expenditures, but they are unlikely to clear the entire market.
3. Great reduction in purchasing power, such as reduction of insurance coverage and elimination of welfare medicine. By definition, this would reduce spending. While proposed by some in the American debate, this is not a realistic public policy. In health, reduction of purchasing power through insurance does not produce an equivalent decrease in utilization and spending, but utilization remains high and hospital managers find the money from welfare programs and from private charity. Reductions in use occur, but they will probably be small, in the light of the patient cost-sharing policies that are likely to be enacted.

Certain institutional arrangements recommended as cost-cutters in the American literature do not have simple consequences. It depends on how they are administered. Or, any cost-cutting effects are restricted to the immediate arrangement and may not benefit the larger health care systems:

1. Competition. In theory, should allocate resources more "efficiently." A large economy would be reduction of services where costs are high and demand is low. In practice in other economic sectors, competitors move in herds: all chase after the customers with money and avoid the poor. Regulation captured by providers is often designed to protect their investments in thin markets; deregulation leads to abandonment of thin markets and leads to temporary stampedes into affluent markets, as recent American transportation shows. Competi-

tion in crowded markets leads to new case-finding, so more producers can survive. Competition in health may increase efficiency and decrease costs in some places; increase the numbers of providers, users, and spenders in other places; and result in fewer departures from their markets than in other economic sectors. While indignant communities cannot block the departure of air routes, they can block the disappearance of medical services. So, health markets cannot be made uniformly competitive everywhere. The health system as a whole can become more expensive.

2. Proprietary instead of nonprofit principles of hospital management. A proprietary hospital at first often appears cheaper. It must keep its charges down, lest patients resist paying the large additional fees to the doctors, which are the raisons d'être for the proprietaries. The proprietaries' charges are limited by the stiff negotiating stance of the official sick funds and by the need for good relations with the private insurance companies. All hospitals cannot adopt a for-profit strategy for all patients: in every country today, the proprietaries handle a different and cheaper patient mix than the nonprofits and publics. They cannot raise from patient charges the massive funds for equipment and staffing required by the more complex and longer-stay cases. If they could, the hospital costs and physicians' fees might make the system more and not less expensive.
3. Public or private ownership. In practice, they behave alike; neither is cheaper. It is organizational constraint rather than nominal ownership that is crucial: whether a hospital is autonomous or part of a larger system.
4. Power of the chiefs of service. Can be cost-saving or cost-increasing, depending on how the chiefs use their power.

#### CONFLICTS

'A system can be expensive not only in money but in contention. Americans are concerned about cutting health care costs but take for granted a level of bickering that is inconceivable in nearly every other

developed country. Weary officials in American governments are belatedly realizing this is a problem, at least as important as the loss of money. The following are some system attributes that result in high and low conflict in hospital regulation:

| <u>Determinant</u>                                      | <u>Higher Conflict</u>                                  | <u>Lower Conflict</u>                   |
|---|---|---|
| Life of the statute                                     | (a) Must be renewed frequently<br><br>(b) Amended often | (a) Permanent<br><br>(b) Amended rarely |
| Power of legislature                                    | High  | Low                                     |
| Role of courts  | Active, overrules regulators and legislators            | Passive, accepts executive discretion   |
| Security of the civil service                           | Low   | High                                    |
| Method of regulation                                    | Automatic formulae                                      | Personal administration                 |
| Complexity of the system in rules and in administration | High  | Low                                     |
| Stability in the rules                                  | Changes are frequent and numerous                       | Changes are rare and few                |
| Coverage of litigation costs                            | Included in budget for care of patients                 | Cannot be passed on to third parties    |

Whether a system is "generous" or "stingy" has no effect on contention. The biggest spenders include a country that placidly accepts government decisions (Sweden) and one that constantly fights and evades them (the United States).

#### HOW TO PAY THE HOSPITAL

Everyone has some complaint about how American hospitals are paid, but the objections vary according to the beholder. Americans seek "answers" by adopting different schemes, tinkering with them constantly, and launching demonstration projects. Policy entrepreneurs seek

notoriety by peddling utopian panaceas. After fifteen years of this, the field of hospital finance is more confused than ever, and the latest cost increases (in 1981) are higher than before.

Instead of inventing convoluted utopias that can never be enacted and implemented, Americans would be better advised to proceed from the methods of other developed countries. No-one has "the answer," everyone wrestles with the frustrations and costs inherent in hospital affairs, but everyone works from certain basic principles.

The uncertainty over hospital payment in America has parallels in the payment of doctors. Americans still have not adopted as public policy by government and third parties certain principles that every other country has found inevitable in the organized payment of doctors, viz., prospective reimbursement, fee schedules (or salary schedules), and machinery for negotiating conditions of service and payment.

Prospective setting of hospital budgets and rates. As long as hospital managers and boards abroad raised their own money from a combination of low charges and charitable fund drives, they could commit themselves to costs first and reimburse themselves later. No large organized payer existed to complain about an unlimited commitment. Actually, no organization could practice truly retrospective reimbursement, even in the days before careful accounting and budgeting. Managers hired and spent in the light of the money they expected to find.

When a large payer assumes all or much of a hospital's operating costs, it always seeks predictability. It must set its own budget for the year, with its own schedule for charging its contributors. Therefore, in every developed country every hospital budget and rate is set in advance. Usually the individual patient's bill is not fixed in advance -- doctors' judgments of the patients' precise needs are made during the stay -- but the rates for each service are. The only retrospectivity occurs over the payment of cost over-runs due to uncontrollable cost increases (such as unexpected wage awards) and greater services -- i.e., whether the organized payers will cover such deficits. As health care costs squeeze everyone, third parties try to keep within their own prospective budgets and become less helpful in meeting the cost over-runs of hospitals.

It is futile for Americans to anathematize retrospective cost reimbursement of hospitals, because it is not possible. Every major third party payer in the United States and in every other country must start the year with interim payments. With time, Blue Cross Plans, Medicare fiscal intermediaries, and state Medicaid agencies -- in a few states aided by regulatory agencies -- are becoming stricter and more expert in reviewing the hospitals' applications and in setting rates. They are becoming stricter in limiting the end-of-the-year settlements. The real issue in the United States -- as in every other country -- is not whether the payment system should be "prospective" or "retrospective" but how prospective budgets and rates should be set and how the end-of-the-year modifications should be performed.

Cost-based reimbursement. Another feat of windmill-tilting in American hospital policy is whether hospitals should be paid their "costs" or their "charges." In theory, a hospital could collect any "charge" it can devise, but in practice it rarely does.

Abroad as well as in much of the United States, cost-based reimbursement of hospitals is now universal. Every statute governing the payment of hospitals under national health insurance or under any other scheme guarantees that the hospital shall be paid its full costs, but the statute usually limits the commitment to "necessary" costs, the costs of the "efficient delivery of care," "economical" costs, or some other qualification. The problem therefore is to distinguish between waste and efficiency, appropriate and excessive claims. In every country, certain services are excluded by law or regulation, and someone makes the distinction. Often it is a civil servant in a regulatory or granting agency, with an appeals process. In rare countries, the decision is made by bilateral bargaining between payers and hospitals. No country -- not even the United States -- leaves implementation of the statutory distinction to the hospital management or to an "invisible hand."

Before statutory cost-based reimbursement, hospitals in every country searched for their own money and charged what they could. Finances were simple; staffing and facilities were crude; and the hospitals went bankrupt as medical care became more sophisticated and as

personnel pressed for adequate wages. The development of third parties and statutory guarantees of reimbursement of costs were designed to save the hospitals and modernize them. When statutes lacked such guarantees and/or when third parties lacked funds (as in West Germany until 1974 and Italy until 1981), hospitals economized by neglecting investments and by squeezing their employees with low pay, long hours, and understaffing.

In practice, payers and providers negotiating budgets and rates always converge on cost-based reimbursement, since it is the only thing they can agree on. In the case of the doctors, fee schedules are cost-plus. Since individual doctors don't allow payers or regulators to investigate their true costs, the negotiators guess at the average doctors' costs for each item. But nonprofit and public hospitals must submit cost reports as the basis of fixing budgets and rates. Third parties in the United States as well as everywhere else work out interim rates with hospitals -- either by bilateral negotiation or via regulation -- that meet expected costs. In practice, the distinction between "charges" and "costs" is muddied: charges are set close to costs.

The real problem is how to calculate costs and distribute them over rates, so that the expected budget is covered. Balancing revenue and the expected budget by this procedure is difficult. A simpler method is merely to pay the agreed budget in installments.

Uniform reporting. Every developed country has uniform reporting by all hospitals to the payers and regulators. Otherwise, the payers and regulators cannot understand the hospitals' cost claims and cannot apply their guidelines concerning allowable costs and the relationship between facilities and utilization. Third parties and regulators evaluate individual submissions in the light of peer group comparisons.

As in other universal features of hospital payment, the United States is clearly evolving toward uniform external reporting and uniform internal accounting. Medicare requires uniform reporting and the other payers go along. Some state regulatory programs require it. Hospitals have a vested interest in delay, since uniform reporting strengthens the hands of payers and regulators. But the trend is inevitable.

Standard rates. In every other country, the same rates within each hospital are quoted for all patients and payers by the regulators. Or, standard rates are negotiated by a panel of payers.

The United States is the last country clinging to different principles of allowable costs for different payers, the last with different payment units within the same hospital for different payers, the last with different prices even when the payment unit is the same. These differentials are among the principal sources of turmoil and administrative cost in American hospital finance. Some state regulatory commissions attempt to standardize more. At times, payers seem to converge slightly; at other times, such as during attempts by the national government to control Mediplan costs, they diverge, leaving hospital managers freedom to manipulate. If and when the United States attempts to plan health finance, standardization must be high on the agenda.

#### MONEY IS A MEANS TO OTHER ENDS

A serious problem in American hospital affairs today is philosophical and ethical. The debate about money and controlling costs loses sight of other things.

The goal of a hospital is not to make money, but to make health. The paradox is that certain hospital workers (the senior doctors and administrators) wish to be very well paid, while other hospital workers wish to be paid no worse than their peers. They work in an establishment that traditionally has been charitable and nonprofit. In other countries, the hospital's traditional nonprofit character has been retained in its management and remuneration; even hospitals incorporated under the business laws are not allowed to earn profits from official insurance money. The United States is the exception, allowing hospitals to make the same profits as only individual office doctors are allowed to do in other countries. Some Americans who equate profit-seeking with efficiency even propose this as a general model.

An organization's character is shaped not only by its own personnel, but also by other organizations that use it. A dilemma for health care in the United States and in other developed countries is

that hospitals have become the opportunities for extremely powerful and affluent industries, viz., instruments, construction, and drugs. American nonprofit hospitals have been passive customers, willing to pay higher prices and buy in large and accelerating volume. They have placed themselves under pressure to pay off debt and buy replacements. Foreign experience shows that hospitals can economize by organizing and prioritizing their purchases; they need not forego innovation.

The leadership of a hospital requires enunciation of its humanitarian purpose, not merely increasing its revenues and expenditures. The introduction of modern financial management into American hospitals has also brought in anomalous styles of thinking. A hospital is thought of as merely one of many possible investments, and a "return on capital" is thought needed to "attract" money into health. A return on capital -- matching the money market rate or the average prime rate plus several more percent -- becomes an allowable cost, at least for all proprietaries and often for others. Inconceivable in other developed countries, this approach is a cost-raising and opportunistic mind set that should not guide donors and managers in health.

Other cost-raising attitudes have spread in other sectors of the hospital. The American manager is induced to think of the money-making potential of equipment. He tries to install equipment that will attract work by physicians who can generate many units of service. The manager and the doctor find a common cause in raising rather than restraining costs.

None of these attitudes are inherent in hospital finance. They are not the general rule abroad in the nonprofit and public sectors and are recent intrusions in American health care. In their stark and maximizing form, they are also recent in American thinking in other economic markets. American businessmen have often been reminded that while profitability is a goal for the firm, it cannot be a final end in life and is only a means to something else. For example, one of the most famous quotations about American economic behavior continues thereafter:<sup>6</sup>

. . . the chief business of the American people is business. They are profoundly concerned with producing, buying, selling, investing and prospering in the world. I am strongly of opinion that the great majority of people will always find these are moving impulses of our life. . . . Of course, the accumulation

of wealth cannot be justified as the chief end of existence. But we are compelled to recognize it as a means to well-nigh every desirable achievement. . . .

Important, however, as [self-interest] is, it is not the main element which appeals to the American people. It is only those who do not understand our people, who believe that our national life is entirely absorbed by material motives. We make no concealment of the fact that we want wealth, but there are many other things that we want very much more. We want peace and honor, and that charity which is so strong an element of all civilization. The chief ideal of the American people is idealism. I cannot repeat too often that America is a nation of idealists. That is the only motive to which they ever give any strong and lasting reaction.

## FOOTNOTES

1. The need for strategic policy thinking and the failures in the Carter Administration are described in Ben W. Heineman and Curtis A. Hessler, Memorandum for the President (New York: Random House, 1980). The chronic disarray over NHI and hospital cost containment is reported in pp. 266-301.

2. I have described the machinery for integrated policy-making in the normally provincial field of health in William Glaser, Federalism in Canada and West Germany: Lessons for the United States (New York: Center for the Social Sciences, Columbia University, 1979; available from the National Technical Information Service).

3. For example, William O. Cleverley, "Evaluation of Alternative Payment Strategies for Hospitals," Inquiry, Volume XVI (Summer 1979), pp. 108-118.

4. For example, Clément Michel, The Cost of Hospitalization (Brussels: Commission of the European Communities, 1979); and Robert Bridgman, Hospital Utilization: An International Study (New York: Oxford University Press, 1980). For some purposes, comparisons of entire nation-wide health sectors can be illuminating, as in Jeremy W. Hurst, "An Aggregate Comparison of the Performance of the American and British Health Sectors" (London: Department of Health and Social Security, 1981).

5. Maurice McGregor, "Hospital Costs: Can They Be Cut?," Health and Society, Volume 59, Number 1 (1981), pp. 89-98.

6. Calvin Coolidge, Address to the American Society of Newspaper Editors, in his Foundations of the Republic (New York: Charles Scribner's Sons, 1926), pp. 187-188 and 190.



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